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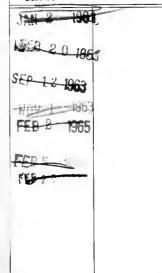
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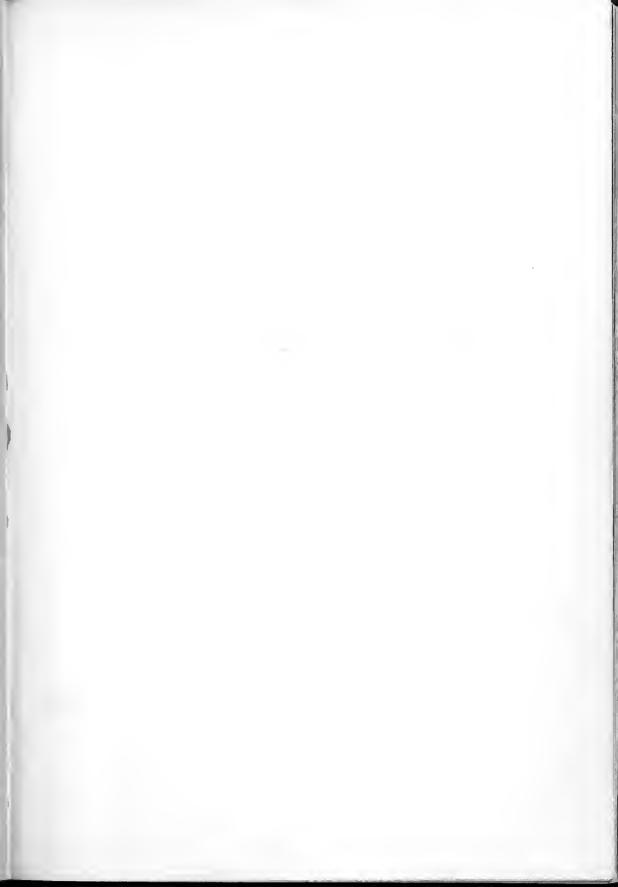


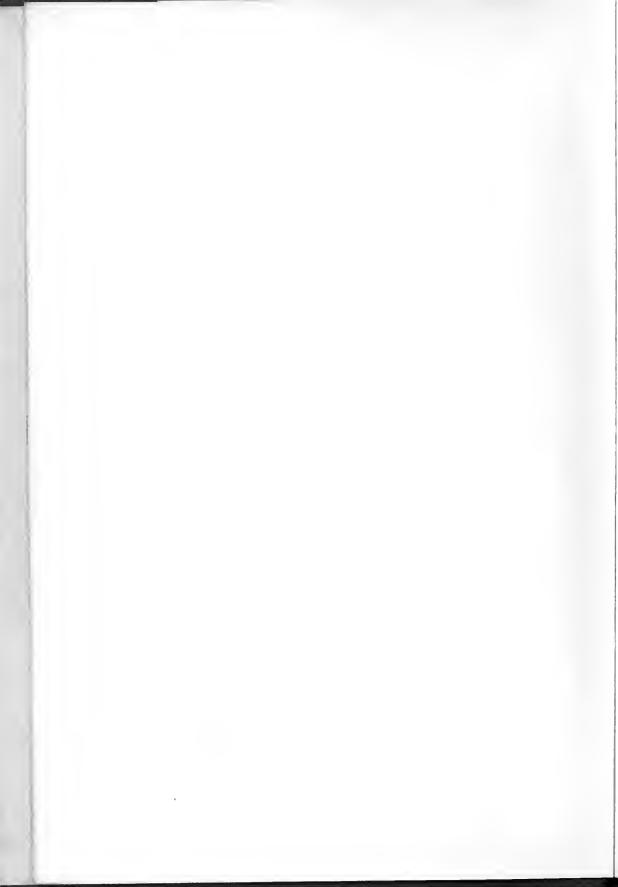
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Medical Journal

Vol. 21 No. 1 January, 1960

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VOLUME 21 NUMBER 1

JANUARY, 1960

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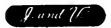
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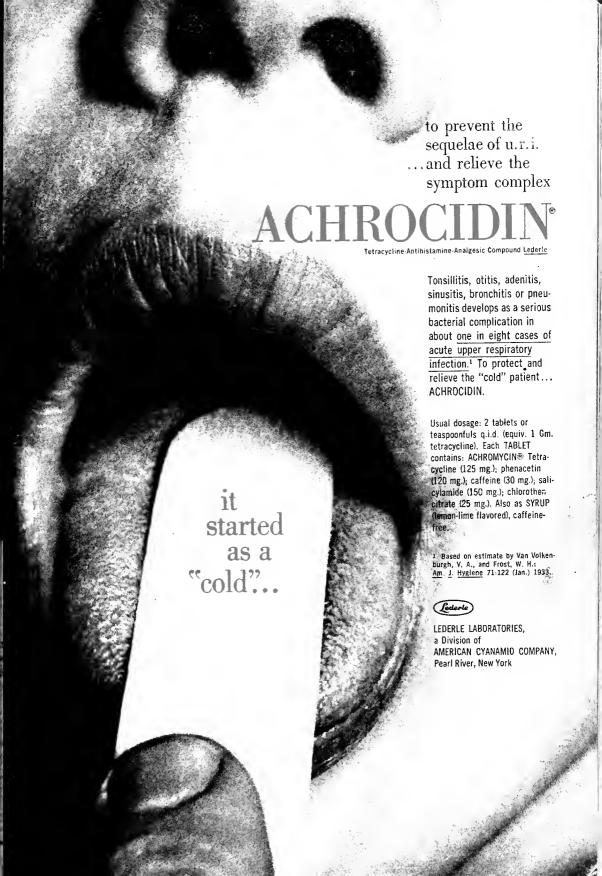
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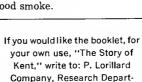
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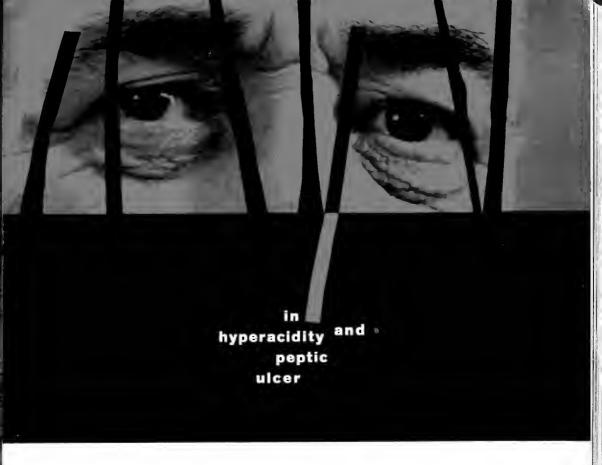
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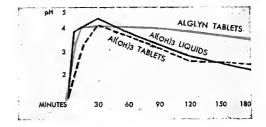


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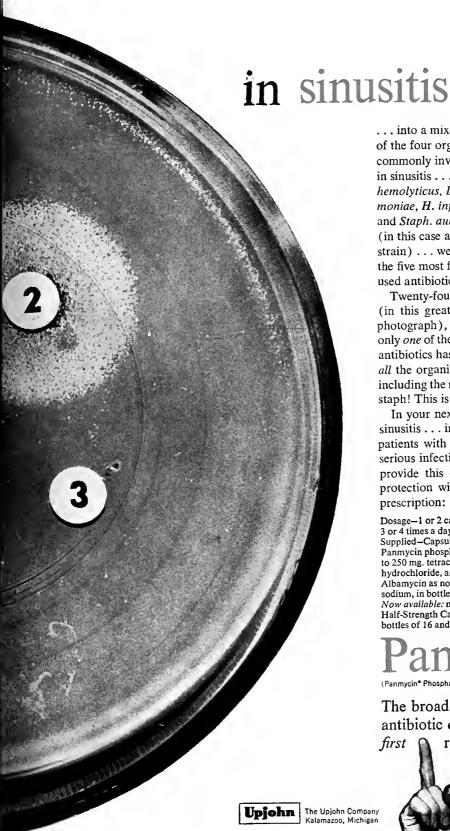
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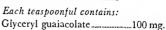


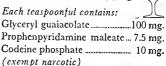
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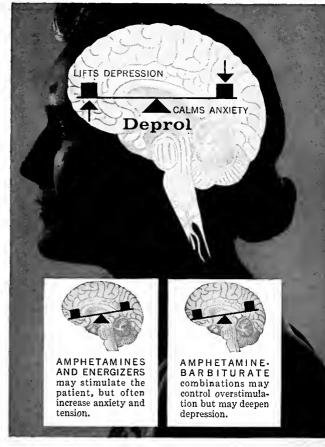
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BIBLIOGRAPHY: 1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-dictiplaminosthy) bazaliste) hydrochieride, J.A.M.A. 166:1019, March I, 1958, Z. Bateman, J. C. and Cariton, H. N.: Deprol as adjunctive therapy for patients with advanced canacr. Antibiotic Med. & Clin. Therapy, in press, 1993, 3. Bell, J. L., Tabuer, H., Santy, A. and Pullio, F.: Treatment of depressive states in office practice. Dis. Nerv. System 20:263, Jun 1959, 4. McClure, C. W., Papas, P. N., Spears, G. S., Palmer, E., Slattery, J. J., Konefal, S. N., Hanken, B. S., Wood, C. A. and Ceresia, G. E.: Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat. in press, 1959. 5. Pennington, V. M.: Meprobamet-benactyzina (Depression—Confidence) in the treatment of chronic brain syndrome, achizophrania and sentility. J. Am. Geristrics Soc. 7:656, Aug. 1959. 6, Rickels, K. and Ewing, J. M.: Deprol in depressive conditions. Dis. Nerv. System 20:364. (Saction One). Aug. 1959. 7. Ruchwarger, A.: Use of Deprol (maprobamate combined with beneartypine hydrochiorids) in the office treatment of depression in the alderly with a meprobamate-beneartypine hydrochioride combination. Antiblotic Med. & Clin. Therapy. In press, 1959

Deprol

DOSAGE: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d. COMPOSITION: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. SUPPLIED: Bottles of 50 light-pink, scored tablets. Write for literature and samples.



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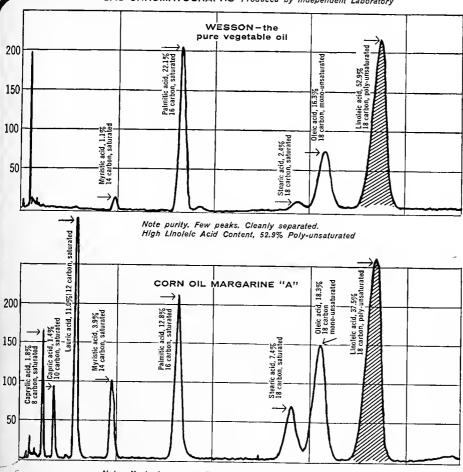
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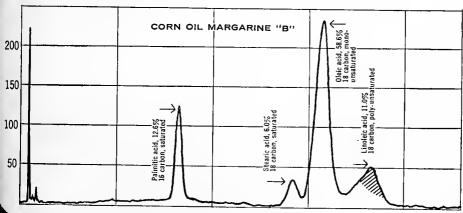
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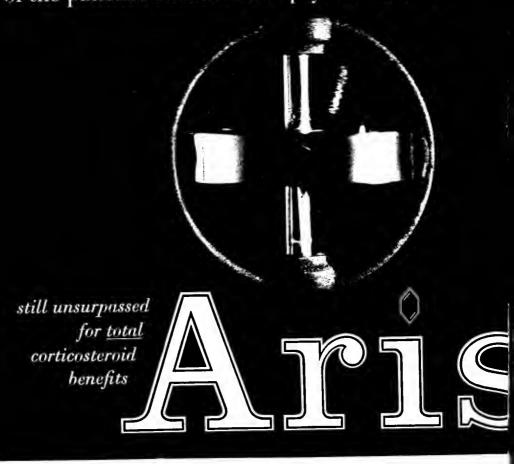


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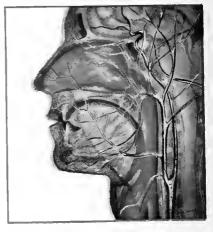
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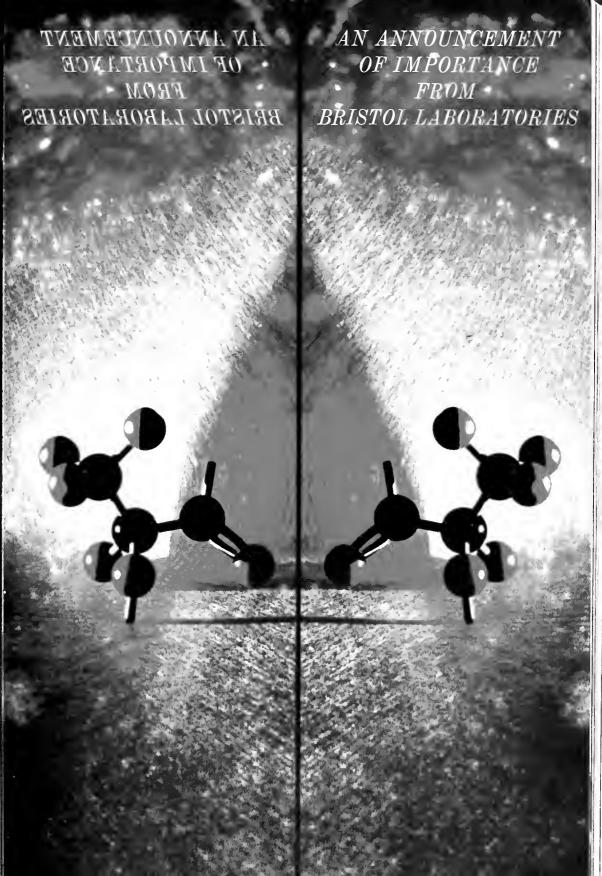
- Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958.
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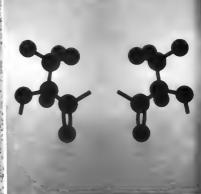
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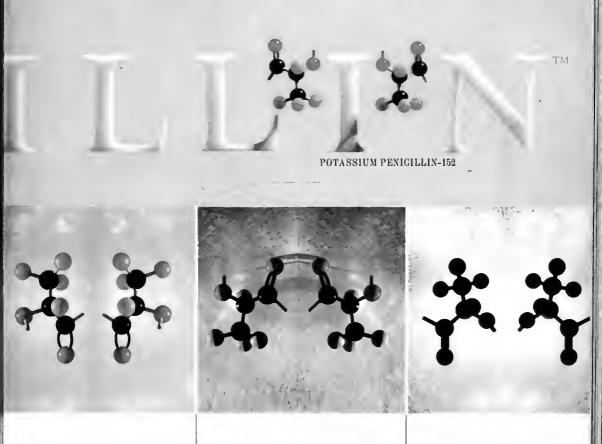






BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V SAFER ORAL ROUTE PROVIDES HIGHER BLOOD LEVELS THAN INTRAMUSCULAR PENICILLIN G IMPROVED
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OF SERIOUS
ALLERGENICITY
BY SAFER
ORAL ROUTE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN



ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and a-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.¹

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH₃ group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH₃ group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.



SYNCILLIN

ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynehacteria; all are ineffective against Salmonella, *E. coli*, and other gramnegative coliform bacilli.

SYNCHLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

TABLE 1

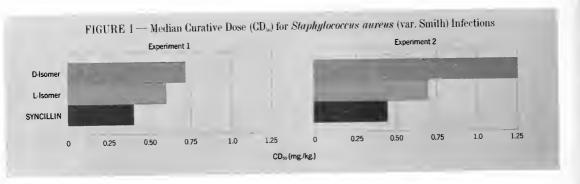
Minimum Concentrations of SYNCILLIN and Components
Required to Inhibit a Wide Range of Bacteria

Bacillus anthracis	L-Isomer 0.06	O-laomer	SYNCILLIN
Perillia satharais		of man	bry
Desillos estas ele			
Dacilius anthracis	~	0.25	0,03
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6.25	6.25
Corynebacterium xerosis	0.06	0.125	0,03
Oiplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0 015	0.125	0.015
Salmonella paratyphi A	25	5 0	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0 007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.125	0.03
Staphylococcus aureus var. Smith	0.03	0.125	003
Streptococcus agalactiae ATCC 1077	0.03	0 06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0 06	0.03
Streptococcus faecalis PCI 1305	6.25	25	6 25
Streptococcus pyogenes 203	0.06	006	0.06
Streptococcus pyogenes Digonnet	0.03 541	0.15	0.06
Streptococcus pyogenes 2320	0.06	0.06	0.03
Streptococcus pyogenes 23586	0.06	0 06	0.06
Vibrio comma	50	25	25



ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

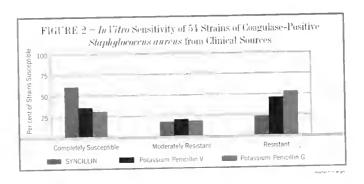
To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.



MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCII LIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright² performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.



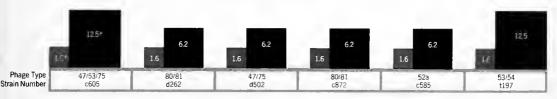


SYNCILLIN

Of equal interest are the findings of White.³ Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit Hospital Strains of Staphylococcus aureus Resistant to Potassium Penicillin V



*Minimum Inhibitory Concentration (MIC) Micrograms per ml.

SYNCILLIN

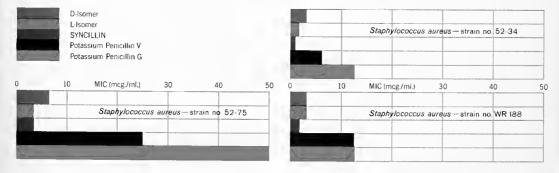
Potassium Penicillin V

The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and wide-spread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive Penicillin-Resistant Strains of *Staphylovoccus aureus*



Isomeric complementarity has thus been demonstrated for:

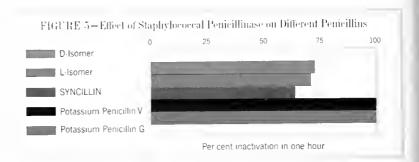
- certain penicillin-susceptible streptococci, staphylococci and corynebacteria in vitro (Table 1)
- --- penicillin-susceptible staphylococci in vivo (Figure 1)
- penicillin-resistant staphylococci in vitro (Figure 4)



ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

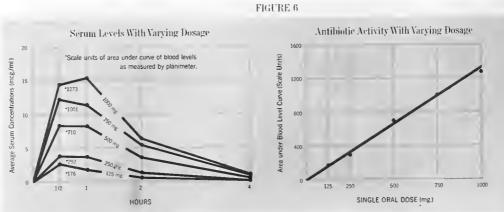
Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.⁴ As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers — a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.



ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

Cronk⁵ studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.





BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright⁶ performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN⁶ are much higher than those with intramuscular penicillin G.^{8a,b} (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal*, these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

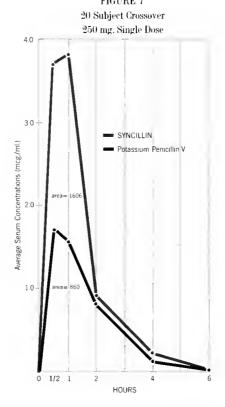
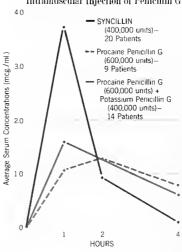


FIGURE 8—Serum Levels after Oral Administration of SYNCHLLIN (250 mg.) and after Intramuscular Injection of Penicillin G





REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. The usual precautions for oral penicillin therapy should be observed. Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

As Flippin⁹ recently stated, "...it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections: the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically: thus the progression of the reaction can usually be interrupted.... In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.¹⁰

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof, ¹¹ White, ¹² Prigot, ¹³ Robinson, ¹⁴ Dube, ¹⁵ Ferguson, ¹⁶ Rutenburg, ¹⁷ Richardson, ¹⁸ Bunn, ¹⁹ Cronk, ⁵ Kligman, ¹⁰ and Yow ²⁰ demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gramnegative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



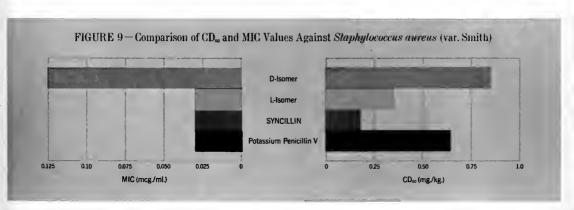
Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the. D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their in vivo and in vitro activities differ for many important pathogens. Against many of the organisms tested, the combination of isomers (SYNCILLIN) is much more active than the stronger isomer alone. This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN (*one-third that of penicillin V*) was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.



Isomeric complementarity has thus been demonstrated for:

- certain penicillin-susceptible streptococci, staphylococci and corynebacteria in vitro (Table 1)
- -- penicillin-susceptible staphylococci in vivo (Figures 1 and 9)
- -- penicillin-resistant staphylococci in vitro (Figure 4)
- -- staphylococcal penicillinase antibiotic inactivation (Figure 5)



Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deepseated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg, or 250 mg, three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg, t.i.d.) may be used for more severe infections, syncillin may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. Therefore the usual precautions with oral penicillin therapy must be observed. Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

 $125\ \mathrm{and}\ 250\ \mathrm{mg}$, tablets, bottles of $25\ \mathrm{and}\ 100, 125\ \mathrm{mg}$, powder for oral solution, $60\ \mathrm{ml}$, vials.

Reference 1. Lein, J., Microbiology report to Bristol Laboratories Inc. 2 Wright, W. W.; Microbiology report to Bristol Laboratories Inc. 3. White, A. C. Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.; Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.; Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.; Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.; Am. J. Med. J. 18764 (May.) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.; in Welch, H. and Marti-Ibañez, F.; Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.; Pennsylvania M. J. 62:864 (June.) 1959. 10. Kligman, A.; Clinical report to Bristol Laboratories Inc. 13. Prigot, A.; Clinical report to Bristol Laboratories Inc. 14. Robinson, C.; Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.; Clinical report to Bristol Laboratories Inc. 16. Ferguson, B., Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M. Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.; Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A. Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.; Clinical report to Bristol Laboratories Inc. 20. Yow,









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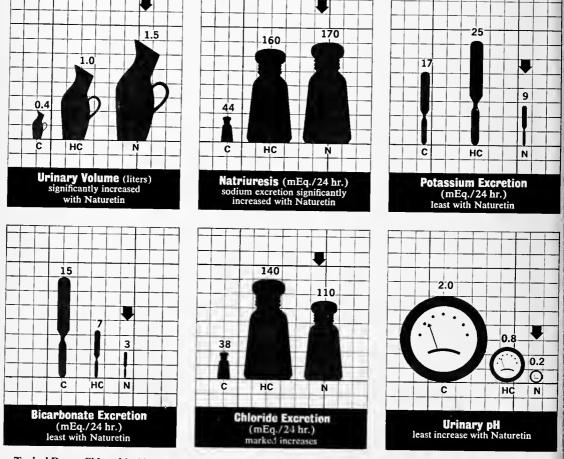
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"When compared to other members of this heterocyclic grou of compounds, this drug [NATURETIN] shows a significantly in causes no significant serum biochemical changes. It is effective in a wide variety of edematous and hypertensive states and represents a significant advance in diuretic therapy." Ford, R.V. Pharmacological observations on a more potent benzothiadiazin diuretic; accepted for publication by the American Heart Journal

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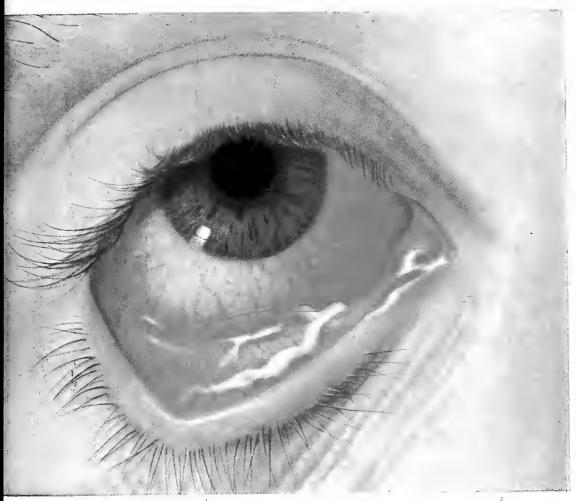
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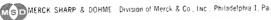
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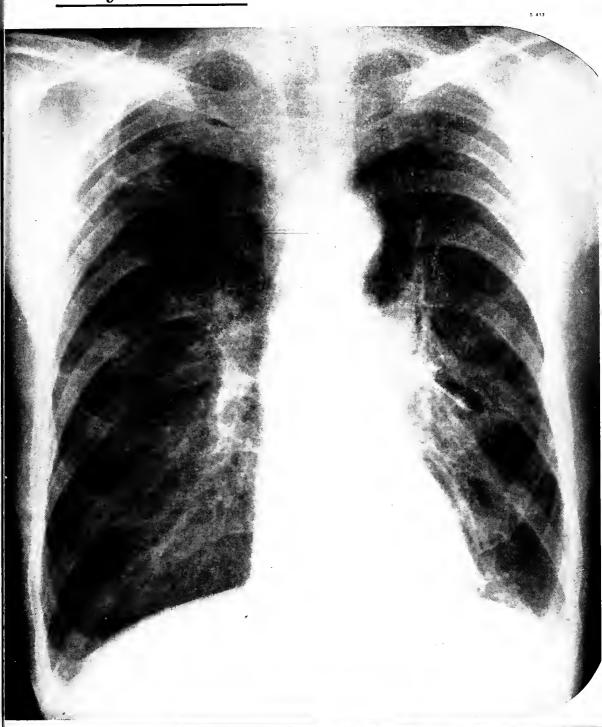


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The Choice of Surgical Procedures In The Treatment of Chronic Pancreatitis

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NEW BERN

The multiplicity of surgical procedures that have been advocated in the management of chronic pancreatitis suggests that the underlying pathologic condition is not factors may be varied, that the same operation is not indicated in every case, and the same in every case, that the etiologic that no one procedure is always successful. These surgical procedures differ in their objectives, result in different physiologic changes, and give varying clinical results.

We are sure of one fact: Chronic pancreatitis is a definite disease entity, and treatment should be instituted early before a loss of pancreatic function occurs. If recurrent episodes of pancreatitis continue without appropriate surgical management, marked changes will occur in the pancreatic parenchyma with resulting internal and external pancreatic insufficiency. If the pathologic process within the gland progresses to the so-called "burnt out" phase, the clinical picture of intolerable pain, weight loss, malnutrition, alcoholism, drug addiction, diabetes and even psychosis may result.

It is true that medical management can be of some value when complications such as diabetes, steatorrhea and malnutrition are present, but as Duval⁽¹⁾ has stated, "time and experience have shown that there is no known method of controlling chronic pancreatitis without surgery."

Etiologic Factors

It is important to review the etiologic factors involved in chronic pancreatitis, because if the significant causative factor in each case can be determined, the surgical objective can be better visualized and the appropriate surgical procedure can be more intelligently selected.

There are many theories concerning the pathogenesis of chronic pancreatitis, but certain ones stand out because of the data that support them and the sound reasoning on which they are based. The most important are (1) the "common channel" theory, (2) obstruction to the outflow of pancreatic secretion, and (3) stimulation of pancreatic secretion.

The "common channel" theory is based on the concept that pancreatitis results from a reflux of bile into the pancreatic ducts. For this to occur, the bile and pancreatic ducts must join above the ampulla of Vater, thus forming a so-called common channel⁽²⁾.

The proponents of this theory believe that when the bile enters the pancreatic ducts under pressure, acinar rupture occurs. The bile then initiates an inflammatory reaction in the pancreatic parenchyma, resulting in pancreatis. It is true that chronic pancreatitis develops in many individuals who do not have this common channel, and therefore this theory cannot explain the pathogenesis of every case.

Obstruction to the outflow of pancreatic secretion may be due to any of the following factors:

1. Congenital abnormalities of the ductal system of the pancreas

2. Impacted stones in either or both of the pancreatic ducts

3. Hyperplasia of the epithelium of the pancreatic ducts

4. Edema or spasm of the sphincter of Oddi

- 5. Impacted stone in the lower portion of the common duct near the sphincter of Oddi
- 6. Tumor in the region of the ampulla of Vater
- 7. Distal compression of the common duct by an enlarged head of the pancreas
- 8. Certain drugs which cause muscle spasm and temporary obstruction at the ampulla.

Experimentally, chronic pancreatitis has been produced by gradual occlusion of the pancreatic duct by the injection of a fibrogenic substance under the serosa of the duct⁽³⁾. One or more of the above mentioned factors in ductal obstruction have been found in operation on patients with chronic pancreatitis, and these patients usually experience relief of symptoms when better drainage of pancreatic secretions has been provided⁽⁴⁾. Against this theory is the known fact that ligation of the pancreatic duct in experimental animals produces atrophy of the pancreas without pancreatitis.

There is evidence, mostly experimental, that an attack of pancreatitis may be induced when pancreatic secretion is greatly stimulated⁽⁵⁾. Shingleton⁽⁶⁾ believes that an increase in pancreatic secretion is an important etiologic factor only when partial or total obstruction to the free flow of pancreatic juice also exists. The latter opinion has been substantiated in experimental animals.

Many other theories such as trauma to the pancreas, interference with pancreatic blood supply, infection, and alcoholism have been advanced, with substantial support in individual cases.

Thus it is obvious that a sure on will not find the same etiologic factor in every case of chronic pancreatitis. As Priestley has aptly stated: "The problem resides with the surgeon to determine as accurately as possible the primary cause of the disease in each individual patient and then direct his efforts accordingly. The success or failure of the surgical treatment of the individual with chronic pancreatitis will then depend on whether the etiological factor responsible for pancreatitis was not relieved at all, was partially or completely relieved, or whether the relief was temporary or permanent."

Based on the etiologic theories mentioned above, the different surgical procedures employed in the treatment of chronic pancreatitis may be grouped into the following categories:

- 1. Procedures on the biliary tract
- 2. Procedures to decrease pancreatic secretion
- 3. Direct procedures on the pancreas
- 4. Procedures designed primarily for the relief of pain

Procedures on the Biliary Tract

At least 33 1/3 per cent of patients with chronic pancreatitis have an associated disease of the biliary tract⁽¹⁾. Corrective surgery of the biliary tract will supposedly control the attacks of pancreatitis in from 40 to 90 per cent of cases⁽⁷⁾. Therefore, it is very important that any abnormal condition of the biliary tract be corrected at the time of the initial operation.

Cholccystectomy and choledochostomy

In the correction of any disease of the biliary tract, the most frequently employed procedures are removal of a diseased gall-bladder which contains stones, plus removal of stone or stones from the common duct. In some cases this is all that is required to relieve the patient and prevent future attacks of pancreatitis.

Sphincterotomy

This operation, which consists of sectioning the sphincter of Oddi, is based on the concept that, due either to fibrosis or spasm of the sphincter of Oddi, a reflux of bile into the pancreatic duct occurs, with resultant pancreatitis. This concept must be based on three premises⁽⁸⁾:

- That the bile and pancreatic ducts join above the ampulla of Vater. Doubilet and Mulholland⁽²⁾ found this to be true in 396 out of 400 cases.
- 2. That because of an increase in tonicity of the sphincter of Oddi, the biliary and pancreatic ducts are converted into a common passageway, allowing bile to be retrojected into the pancreatic duct.
- 3. That section of the sphincter of Oddi will halt the progress of the disease. Doubilet⁽²⁾ obtained good results in 90 per cent of the patients with chronic pancreatitis on whom he performed this procedure. The results of many other surgeons have been less encouraging.

Many techniques have been advocated for section of the sphincter of Oddi. The operation may be done transduodenally or through the common duct. If the transduodenal approach is used, the technique may range from simple incision of the sphincter without the use of sutures, to the actual excision of a wedge-shaped portion of the sphincter. If the operation is done through the common duct, a special instrument is usually necessary. Some advocate that the sphincter be sectioned for a distance no greater than 8-10 mm. so that the circular muscle of the duodenum will not be cut. Others say that this precaution is unnecessary.

It has been advocated that a pancreatogram be done after the sphincter has been sectioned (2). A small plastic tube is inserted into the duct of Wirsung for several inches. About 10 cc. of radiographic solution is injected slowly through the tube over a five-minute period. X-ray films are taken during the injection of the last 2 cc. of the solution. Any existing obstruction must be relieved. If the pancreatic duct is dilated, or if the pancreas has been incised to remove stones, the plastic tube is left in the duct for drainage. The progress of the inflammation can be followed by repeated pancreatograms.

This operation alone is ineffectual if the pancreatic ducts are partially or totally obstructed. Also, it is of little value in alcoholics and those who persist in eating fatty foods.

Biliary-intestinal anastomosis

When obstruction exists in the region of the ampulla of Vater, many surgeons prefer some type of biliary-intestinal anastomosis to sphincterotomy. This operation is also predicated on the theory that the regurgitation of bile due to an obstruction in the region of the ampulla is the main etiologic factor in chronic pancreatitis.

A Roux-en-y choledochojejunostomy is probably the most widely advocated type of biliary-intestinal anastomosis used in these cases. Bowers⁽⁷⁾ reported excellent results in 16 out of 17 cases of chronic pancreatitis in which he employed this procedure. The technical steps in the operation include division of the jejunum, division of the common duct, cholecystectomy if the gallbladder remains, an anastomosis between the upper end of the common duct and the

lower end of the jejunum, an end-to-side jejunojejunostomy, and the insertion of a T tube into the common duct.

The main disadvantages of this operation are (1) that it necessitates dividing the common duct, and (2) that a stricture of the choledochojejunal anastomosis may occur. Another objection is that although this operation does sidetrack the flow of bile and prevent reflux into the pancreatic ductal system, it does not reduce pressure within the system⁽⁸⁾.

Some surgeons prefer a side-to-side anastomosis between the common duct and the duodenum. Womack⁽⁹⁾ states that this operation has given adequate drainage of the common duct, and that he and his associates have resorted to it because of their disappointment with the results of sphincter-otomy.

Procedures Designed to Decrease Pancreatic Secretion

As mentioned previously, it has been shown that an attack of pancreatitis may be induced when pancreatic secretion is greatly stimulated. We know that the external secretion of the pancreas is under both neural and hormonal control. Vagal nerve stimulation causes an increased output of pancreatic juice, and vagal inhibition causes the opposite effect (6). In 1901 Bayliss and Starling(10) discovered that secretin, which is elaborated in the duodenum and upper small intestine, has a stimulating effect on the output of pancreatic juice. In the digestive process, when food enters the stomach, a reflex vagal stimulation of pancreatic juice occurs, and when acid chyme enters the duodenum, secretin is elaborated and pancreatic secretion is further stimulated(6).

Based on these physiologic facts, the following operations have been advocated in an effort to decrease the output of pancreatic juices:

1. Vagotomy(11)

2. Vagotomy and gastroenterostomy(11)

3. Vagotomy and subtotal gastrectomy(12)

4. Subtotal gastrectomy (12,13).

Definite logic underlies these operations, but most surgeons who have used them have reported disappointing results.

The opinion has been expressed that gastrointestinal diversion should be performed in chronic pancreatitis only when there is some co-existent disease of the stomach and

duodenum which in itself warrants diversion $^{(14)}$.

Direct Operations on the Poncreas

In recent years direct operations on the pancreas have been employed more and more frequently in the management of chronic pancreatitis. The necessity for this direct approach is based upon the finding of partial or complete obstruction of the duct of Wirsung, the duct of Santorini, or both, in a large percentage of patients with chronic pancreatitis.

Pancreatolithotomu

Stones in the pancreatic ducts may be demonstrated by preoperative x-ray examination, by palpation of the gland at operation, or by pancreatograms. If stones are demonstrated in the ducts, they should be removed. The stones are usually multiple and may cause several areas of obstruction. In some cases incision of the duct and removal of the stone may be all that is necessary to give complete relief. As a rule, however, unless pancreatolithotomy is combined with other maneuvers to relieve the obstruction, it has very little to offer in the management of chronic pancreatitis.

Pancreatolithotomy may be performed in one of two ways(15):

- By direct incision of the pancreas over the stone followed by suture of the incised area.
- 2. By transduodenal approach when a stone is present in the duct of Wirsung near the ampulla. After the stone has been removed the pancreatic ducts are probed, the gland is carefully palpated, and a pancreatogram is performed to rule out the possibility of other stones being present.

Transduodenal exploration and dilatation of the pancreatic ducts

This operation has been advised for patients with moderately advanced chronic pancreatitis in whom it is felt that more radical procedures are neither justifiable nor necessary. In this operation, after adequate mobilization of the duodenum and head of the pancreas, the common duct is opened and an anterior duodenostomy performed. A sphincterotomy is then done. The ostium of the duct of Wirsung is identified, and a probe is inserted into the main pancreatic duct. If obstruction is met, the ostium is further incised. The point of obtients

struction may be relieved by dilatation with a Bakes dilator. Many surgeons oppose this measure, however, because of the possibility of residual scarring and contraction of the duct. In many cases, pancreatic stones will be encountered distal to the point of obstruction and can be easily removed. Small stones can be removed by irrigation of the duct with saline. The duct of Santorini should also be explored, particularly in those cases where there is obvious pancreatic obstruction but no obstruction in the duct of Wirsung. Both ducts may be obstructed in diffuse calcification of the head of the pancreas.

Retrograde surgical drainage of the pancreas

In those patients who have chronic pancreatitis without a concomitant disease of the biliary system, it has been found, as mentioned previously, that usually the pancreatic ductal system is obstructed. Several operations have been devised to relieve the obstruction by internal drainage of the pancreas.

Pancreaticojejunostomy: Probably the simplest method for decompressing an obstructed ductal system is the creation of an internal pancreatic fistula from the tail of the pancreas to the small intestine by means of a Roux-en-y pancreaticojejunostomy. It has been demonstrated that pancreatic juice can flow toward the tail of the pancreas as well as toward the head⁽¹⁷⁾. Thus decompression of the ductal system can be achieved satisfactorily via the tail of the pancreas.

Before making the decision to perform this particular operation, DuVal(16) transects the tail of the pancreas and injects a 70 per cent solution of Diodrast through a cannula inserted into the main pancreatic duct. If there is roentgen evidence of obstruction to the flow of bile into the duodenum, or if an enlarged, dilated or tortuous duct exists, pancreaticojejunostomy is performed. In 1957 DuVal(17) reported 26 patients with chronic pancreatitis who were treated by this operation. Three years following surgery all patients had gained weight and felt improved. In 1958 Jordan and Howard(18) reviewed the literature and found 57 cases of patients with chronic pancreatitis who were treated by caudal pancreaticojejunostomy. Good results were reported in 75 per cent of the cases. In

their own series of 7 cases thus treated, satisfactory results were obtained in only 2. This is the procedure preferred by Womack and his associates. They advocate excising the tail of the pancreas and a considerable portion of the body of the pancreas before performing the anastomosis. In this manner the volume of external secretion is greatly diminished, a factor of great importance in alleviating pain.

Puestow⁽¹⁹⁾ obtains internal drainage of the pancreas in a somewhat different manner. He contends that chronic pancreatitis is a disease that exists throughout the pancreas and that in order to obtain a satisfactory surgical result extensive and ade-

quate drainage must be obtained.

The entire length of the pancreatic duct is exposed, and the tail of the pancreas is resected. He has found that the establishment of pancreatic drainage into the intestinal tract is best obtained by a pancreaticojejunostomy, either by slipping the jejunum over the opened pancreas or by a side-to-side anastomosis between the opened pancreas and the jejunum. A Roux-en-y procedure is performed in either case. He reported 21 cases so treated, with no operative mortality. In 19 of the 21 cases, the results have been satisfactory.

Pancreaticogastrostomy: Puestow⁽¹⁹⁾, in 1958, reported 2 cases of chronic relapsing pancreatitis that were treated by pancreaticogastrostomy. At operation he opened the pancreas as far to the right as possible and anastomosed the edges of the pancreas to the stomach, leaving the opened pancreas in the lumen of the stomach. It is too early to evaluate the results of this procedure, but eight months after the operation the convalescence of both patients was excellent.

Anastomosis of the duct of Wirsung to the gastrointestinal tract: In 1947 Cattell(20) first reported this operation and advocated its use in carcinoma of the pancreas. In 1956 he recommended that it be employed in those patients with chronic pancreatitis who were too ill or had too much peripancreatitis to permit more radical procedures. The operation does not require division of the pancreatic duct or resection of the tail of the pancreas in order to decompress the obstructed duct. If the duct is dilated, a side-to-side anastomosis may be made between it and a loop of je-

junum. If the duct is normal in size, it is sutured to the jejunum by a necrosing suture technique.

Ligation of the pancreatic ducts

Martin and Canesco (21), in 1947, reported ligation of the pancreatic ducts in the treatment of chronic pancreatitis. The concept behind this operation is that physiologically it will preserve the endocrine function of the pancreas and at the same time destroy the exocrine function, which is held by many to be responsible for the disease(22). It has been shown in experimental animals that ligation of the pancreatic ducts causes atrophy of the acinar portion of the pancreas, with destruction of the exocrine function of the gland. Cannon (23), in 1955, reported 6 cases thus treated. He recomends this procedure only as a possible alternative to pancreatic resection and then only if generalized pancreatic involvement is present In his series of 6 cases results were good in 2 cases, and in another the operation was too recent to permit full evaluation.

Pancreatoduodenectomy

This operation is most frequently advocated when the head of the pancreas is involved extensively, usually in association with relatively localized pancreatic calcification and lithiasis. In 1953, Cattell and Warren(24) expressed the opinion that pancreatoduodenectomy was the procedure of choice in many cases of chronic relapsing pancreatitis. It is a formidable procedure, but in recent years it has been accomplished with a decreasing mortality (14,25). As a rule the results have been excellent, Many surgeons advise that it be employed only after less radical procedures have failed. Longmire(25) report q cases thus treated. Follow-up studies langing from six months to five and one-half years were considered excellent in 5 cases and improved in 2 cases. Diabetes did not occur in any cases. The nutritional states of the patients postoperatively were variable.

Distal pancreatectomy

This procedure is indicated when the pathologic process is localized to the distal part of the pancreas. Usually the entire portion of the gland distal to the neck has to be removed. It is wise to save some pancreatic tissue whenever possible, even though that portion may be involved [26].

Thus some pancreatic function will be preserved.

Total panercatectomy

This procedure is also a formidable one. A review of the literature in 1956(25) revealed that only 8 total pancreatectomies had been performed in this country for chronic pancreatitis. The high mortality and the profound physiologic disturbances, combined with the discouraging long-term results, limit the indications for this procedure. Disturbances in liver function result. However, insulin requirement is very low. Mulholland(27) says that sprue and diabetes result from extirpation of the entire pancreas. He does not think that this is a fair exchange for relief of pain when the gland is salvageable and has great regenerative powers once the obstructing mechanism causing pancreatitis is relieved.

The majority of surgeons believe that the mortality following pancreatectomy is too high to justify its application in a benign disease unless all other means of therapy have been ineffective.

Treatment of pseudocysts

Almost all of the cysts which are secondary to pancreatitis are pseudocysts. A pseudocyst has been defined as a collection of fluid and necrotic tissue resulting from the action of the pancreatic enzymes (28). The collection of pancreatic juice is surrounded by a pseudo-wall of compressed tissue, usually made up of other organs in the region. Thus a pseudocyst is not lined with epithelium. It does not disappear spontaneously and may rupture, with a fatal outcome.

During the past decade the surgical management of pseudocysts has undergone many revisions. The following operations have been advocated:

- 1. External drainage
 - a. Marsupialization
 - b. External catheter drainage
 - c. Transgastric catheter drainage
- 2. Internal drainage
 - a. Cystogastrostomy
 - b. Cystojejunostomy (Roux-en-v)
 - c. Cystocholecystostomy
- 3. Sphincterotomy
- 4. Excision

In choosing an operation for this condition, one should consider the mortality, and the necessity for secondary operations.

External drainage by one of the above

mentioned techniques was formerly the most generally accepted method of treatment. It has the advantage of simplicity; but the cysts usually drain for months, there may be digestion of the skin and abdominal wall, and roughly 25 per cent of the patients so treated require further operative treatment because the cyst is not cured.

Excellent results have been reported in the management of pseudocysts by sphincterotomy⁽⁸⁾. It is important that an operative pancreatogram be performed, and if a stone is present in the pancreatic duct, it must be removed or the operation will be a failure.

Excision of the pseudocyst, if feasible, would be the ideal procedure. Actually it is impracticable, because the walls of the cyst are usually made up of neighboring organs. In only 5 to 15 per cent of cases reported in the literature has it been possible to remove a pseudocyst.

The most gratifying results have been obtained by internal drainage, either by the transgastric method, when applicable, or by a Roux-en-y anastomosis between the cyst and jejunum.

Procedures for the Relief of Pain

In advanced pancreatitis, constant and intolerable pain may accompany pancreatic insufficiency. Many surgical procedures have been advocated when this stage is reached, the sole purpose of the majority being relief of pain. Rayrann has shown that pain fibers from the pancreas pass through the celiac ganglion and then through the greater splanchnic nerves. This observation has been the basis for the following operations:

- Unilateral and bilateral splanchnicectomy⁽²⁹⁾
- 2. Splanchnicectomy and vagotomy (12,29e)
- 3. Celiac ganglionectomy (29c)
- Celiac ganglionectomy and bilateral splanchnicectomy (29e,30)
- 5. Sectioning of postganglionic fibers from celiac ganglion to pancreas⁽¹²⁾
- 6. Sympathectomy (29b,d)

Shingleton⁽⁶⁾ believes that celiac ganglionectomy is the procedure of choice because (1) it decreases pancreatic secretion; (2) it prevents or relieves the spasm of the sphincter of Oddi; (3) it relieves pain; (4) it improves pancreatic blood flow. The early results of these operations are good, but there are not enough five-year postoperative evaluations to pass final judgment as to their worth.

Conclusions

It is of utmost importance that appropriate surgical treatment of chronic pancreatitis be instituted before there is marked destruction of the pancreatic parenchyma. The many variations and pathologic findings encountered in patients with this complex condition make it absolutely necessary that surgeons be familiar with the various procedures in order to select the appropriate one for the individual patient. No single operation will be applicable to every case. If doubt exists at the operating table as to the main pathologic condition to be corrected, it would seem wise to employ a conservative operation first. Often this will be successful, If it should fail, a more radical procedure can be performed later. If the etiologic factor in the individual case can be accurately determined, the choice of operation will be greatly simplified.

References

- Duval, M. K. Jr.: Pancreaticojejunostomy for Chronic Relapsing Pancreatitis; Current Surgical Management, Philadelphia, W. B. Saunders Co., 1957, pp. 21-26.
- Doubitel, H., and Mulholland, J. H.: Eight-Year Study of Pacereatitis and Sphincterotomy, J.A.M.A. 160:521-628 (Feb. 18) 1986.
- Floyd, C. N., and Christopherson, W. M.: Experimental Chronic Pancreatitis. A.M.A. Arch. Surg. 73:701-709 (Oct.) 1956.
- Warren, K. W., and Cattell, R. B.: Basic Technique in Pancreatic Surgery, S. Clin. North America 36:707-724 (June) 1956.
- Priestley, J. T.: Pancreatitis, S. Clin. North America, 37:953-964 (Aug.) 1957.
- Shingleton, W. W.: Chronic Relapsing Pancreatitis, J. Chron. Dis. 5:253-269 (Feb.) 1957.
- Bowers, R. W.: Choledocheojejunostomy for Recurrent Pancreatitis; Current Surgical Management, Philadelphia. W. B. Saunders Co., 1957, pp. 27-33.
- Doubilet, H.: Treatment of Recurrent Pancreatitis by Sphinctectomy; Current Surgical Management, Philadelphia, W. B. Saunders Co., 1967, pp. 35-38.
- 9. Womack, N.: Personal communication.
- Bayliss, W. M., and Starling, E. H.: The Mechanism of Pancreatic Secretion, J. Physiol. 28:325, 1902.
- McCleery, R. S. Kesterson, J. E.: and Schaffarzick, W. R.: A Clinical Study of the Effect of Vagotomy on Recurrent Acute Pancreatitia, Surgery 30:130-146 (July) 1961.

- Richman, A., and Colp. R.: Chronic Relapsing Pancreatitis: Treatment by Subtotal Gastrectomy and Vagotomy Ann. Surg. 131:145-158 (Feb.) 1950.
- Johnson, W. M.: Subtotal Gastrectomy in the Treatment of Chronic Recurrent Pancreatitis, Gastroenterology, 14:590 (April) 1950.
- Warren, K. W.: Surgical Considerations in the Management of Chronic Relapsing Paucreatitis, S. Clin. North America 35:785-799 (June) 1955.
- Maingot, R.: Abdominal Operations, New York, Appletou-Century-Crofts, Inc., 1948, p. 812.
- DuVal, M. K. Jr.: Caudal Pancreaticojejunostomy for Chronic Relapsing Pancreatitis. Ann. Surg. 140:776-785 (Dec.) 1954.
- DuVal, M. K. Jr.: Pancreaticojejunostomy for Chronic Pancreatitis, Surgery 41:1019-1128 (June) 1957.
- Jordan, G. L., Jr., and Howard, J. M.: Caudal Pancreatojejunostomy in the Management of Chronic Relapsing Pancreatitis, Surgery 44:303-311 (Aug.) 1958.
- Puestow, C. B., and Gillesby, W. J.: Retrograde Surgical Drainage of Pancreas for Chronic Relapsing Pancreatitis, Arch. Surg. 76:898-906 (June) 1958.
- Cattell, R. E.: Anastomosis of the Duct of Wirsung: 1ts Use in Palliative Operations for Cancer of the Head of the Pancreas. S. Clin. North America, 27:636-643 (June) 1947.
- Martin, L., and Cauesco, J. D.: Pancreatic Calculosis, J.A.M.A. 135:1065-1060 (Dec.) 1947.
- Banting, F. G. and Best, C. H.: Internal Secretion of Pancreas. J. Lab. & Clin. Med. 7:251, 1922.
- Cannon, J. A.: Experience with Ligation of the Pancreatic Ducts in the Treatment of Chronic Relapsing Pancreatitis, Am. J. Surg. 90:266-280 (Aug.) 1955.
- Cattell, R. B., and Warren, K. W.: Surgery of the Paccreas, Philadelphia, W. B. Saunders Co., 1953.
- Longmire, W. P., Jr., Jordan, P. H., Jr., and Biggs, J. D.: Experience with Resection of the Pancreas in the Treatment of Chronic Relapsing Pancreatitis, Ann. Surg. 144:681-695 (Oct.) 1956.
- Cattell, R. B.: Discussion of the Presentation of Longmire, W. P., Jordan, P. H., Jr., and Biggs, J. D. (25).
- Mulholland, J. H.: Discussion of the Presentation of Longmire, W. P., Jordan, P. H., Jr., and Biggs, J. D., (25).
- Wilson, H., and Baugh, C. M.: Pancreatic Cysts Secondary to Pancreatitis: Diagnosis and Surgical Treatment, Am. Surgeon 25:26-27 (Jan.) 1969.
- 29. (a) deTakats, G., Walter, L. E., and Lasner, Jr.: Splanchnic Nerve Section for Pancreatic Pain; Second Report, Ann. Surg. 131:44-87 (Jan.) 1950. (b) Ray, B. S., and Console, A. D.: Relief of Pain in Chronic (Calcareous) Pancreatitis by Sympathectomy, Surg., Gyoec., & Obst. 89:1-8 (July) 1949. (c) Grimson, K. S., Hesser, F. H., and Kitchio, W. W.: Early Clinical Results of Transahdominal Celiac and Superior Mesenteric Ganglionectomy, Vagotomy, or Transthoracic Splanchniecetomy in Patients with Chronic Visceral Pain, Surgery 22:230-238 (Aug.) 1947. (d) Hurwitz, A., and Gurwitz, J.: Relief of Pain in Chronic Relapsing Pancreatitis by Unilateral Sympathectomy, Arch. Surg. 61:372-378 (Aug.) 1950. (e) Mallet, Guy, P. and de Beaujeu, M. J.: Treatment of Chronic Pancreatitis by Unilateral Splanchnicectomy, Arch. Surg. 60:233-241 (Feb.) 1950.
- Coffey, F. L., Woelfel, G. F., David, K. J., and Burdette,
 M. G.: Treatment of Chronic Relapsing Pancreatitis. Am.
 Surgeon 21:869-576 (June) 1985.

Changing Concepts In Preoperative Medication

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Traditionally, the reasons for prescribing preoperative medication may be classified into several categories, each of which has had its proponents through the years.

1. The reduction of fear and apprehension towards the forthcoming operative

procedure is a universal desire.

2. The promotion of a feeling of serenity and absence of anxiety, coupled possibly with drowsiness, is a positive effect which one should strive for in association with the numbing of fear.

3. The relief of pain prior to induction of anesthesia has been cited as advanta-

geous to patient and anesthetist.

4. The inhibition of salivary secretions by suitable drugs is believed to be a fundamental reason for preoperative medication.

- 5. Many physicians have utilized preanesthetic drugs to promote a smoother and easier induction of anesthesia. It was for this reason that preoperative drugs were first introduced at a time when ether and chloroform were the only anesthetics known.
- 6. Many anesthetists believe that preoperative medication in adequate amounts contributes to the state of anesthesia and reduces the amounts of general anesthetic drugs required.
- 7. Finally, anticholinergic drugs have been employed preoperatively to reduce the incidence and severity of parasympathetic, and particularly vagal, reflexes. This reason perhaps is more recent in origin and is associated with the trend to lighter planes of general anesthesia.

Criticisms of Premedication

Conventional preoperative medication consists of the subcutaneous administration of a narcotic drug—for example, morphine or meperidine—and an anticholinergic drug, such as atropine or scopolamine. In many hospitals physicians also prescribe a short-acting barbiturate—for example, pentobarbital or secobarbital to enhance sedation.

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Within recent years an increasing number of criticisms have been leveled at certain aspects of the traditional premedication schedule. Most of these attacks have been aimed at the use of narcotic drugs, and they may be delineated as follows:

- 1. Narcotics do not relieve anxiety and fear more selectively than do other sedative drugs(1).
- 2. The administration of narcotics preoperatively does not induce a feeling of serenity or euphoria, as is commonly believed. In a series of experiments on healthy subjects, Beecher and his group concluded that morphine and heroin were not pleasant drugs to the majority of patients⁽²⁾.
- 3. The analgesic effectiveness of narcotic drugs is undeniable, but the majority of patients coming to operation today are not suffering from pain. Therefore, this particular indication for the administration of these drugs usually is invalid.

4. Recent controlled studies have indicated that, when inhalants are used for general anesthesia, the preanesthetic administration of narcotics does not influence the amount of anesthetic drugs required durated

ing surgery (1.3).

- 5. The unpredictable side effects of narcotic drugs are a powerful argument against their routine use in preanesthetic medication. Both respiratory and cardiovascular depression are undesirable complications and may be dangerous, particularly in the geriatric age group. Nausea and vomiting are most unpleasant for the patient. Unfortunately, these ill effects may persist into the postoperative period and complicate smooth and rapid recovery from anesthesia.
- 6. The argument has been advanced that the use of narcotics preoperatively may open the pathway to addiction.
- 7. The routine and thoughtless administration of anticholinergic drugs preoperatively may be unwarranted and actually hazardous. In the geriatric age group and in "cardiacs," the associated tachycardia may help to precipitate cardiac failure. When spinal or regional analgesia is employed, the drying of the mouth associated

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with the administration of anticholinergics can be most uncomfortable and irritating. Moreover, many of the anesthetic drugs utilized today do not stimulate salivary secretions.

These criticisms, along with the recent introduction into medicine of new types of sedative compounds, are creating a quest for new ideas and trends in preoperative medication. The barrier of the traditional concept is being whittled away and broken down. Today anesthetists are searching for non-narcotic drugs or combinations which will allay fear and produce an attitude of serenity without upsetting the integrity of the vital functions of respiration and circulation. If drowsiness can be combined with a tranquility of the mind, so much the better. The antisialogogue drugs, particularly those which blunt the action of the vagus nerve upon the heart, will, it is believed, continue to be an important ingredient of preoperative medication for general anesthesia. Without them the parasympathetic reflexes engendered by anesthetic drugs or by surgical stimulation in light planes of anesthesia can interfere drastically with myocardial function. While the original indications for anticholinergic drugs may have altered somewhat, their value in the schedule for most patients is beyond criticism.

Newer Concepts

If it is assumed that narcotic drugs are to be stricken from their preoperative role, what types of sedative compounds may be considered as replacements? Of the old standbys, one should consider seriously the short-acting barbiturates, exemplified by secobarbital and pentobarbital. These hypnotic drugs have stood the test of time and, in moderate dosages (100 to 180 mg.), are capable of inducing somnolence and abrogation of fear. Eckenhoff's series(3) indicated that secobarbital led to a high proportion of calm and carefree patients. In the doses mentioned, these compounds have minimal deleterious effects on respiratory and cardiovascular functions.

Within the last nine years the country has been beseiged with the doctrine of tranquilization. It is only natural that anesthesiologists should become interested in the possibility of adapting some of these loosely-knit groups of drugs for preoperative medication.

One group, represented by meprobamate, "the executive's assistant," has been evaluated for preoperative use, but found wanting. Meprobamate does not depress the autonomic nervous system, nor does it potentiate the action of hypnotic drugs⁽⁴⁾. The calming effects of this drug are not pronounced, and it has minimal value in stemming the apprehension of patients prior to operation.

The reserpine group of compounds also has little value in preoperative medication (5). Their effect is not manifest for several days after beginning administration, and then their cerebral sedative action is not pronounced in most patients. The patient who has been receiving reserpine preoperatively should be watched closely for the development of hypotension during anesthesia; this complication can be minimized by relatively large doses of anticholinergic drugs administered as preoperatively.

It is the phenothiazine compounds which have received the greatest attention from anesthesiologists. These drugs are appearing in such profusion that nearly every letter of the alphabet is represented. Interest in these compounds is derived from their sedative properties, their ability to enhance the sedation produced by hypnotic and narcotic drugs, and their antiemetic action. For several years chlorpromazine was boosted as a valuable preoperative sedative. More recently its superiority as a sedative has been questioned and its safety challenged because of its potential adrenolytic action, which can lead to severe hypotensive episodes(6). There are few anesthesiologists today who believe the sedative value of chlorpromazine outweighs its potential hazards for preoperative medication.

On the other hand, promethazine has stimulated and is continuing to stimulate considerable interest as a premedicant. Although when administered alone it produces little sedation, it does potentiate the action of hypnotic and narcotic drugs, so that reduced doses of the latter, when combined with promethazine, result in satisfactory preoperative sedation⁽⁷⁾. This phenothiazine compound in clinical dosage (up to 50 mg.) has little deleterious effect on vital functions⁽⁸⁾. One wonders, however, what advantage there is in combining a drug

Table 1
Effects of Glutethimide Used Alone

Effects	Glutethimide 58 Patients	Placebo 57 Patients
Wide awake	51%	61%
Apprehensive	19	22
Alert	57	58
Drowsy	13	15
Asleep	0	2
Calm	81	70

(115 patients)

like promethazine with a reduced dosage of a hypnotic or narcotic, if the same effect can be obtained with the conventional dose of the hypnotic or narcotic alone.

A number of other phenothiazine compounds have been investigated for preoperative use. None possess outstanding advantages, and the search continues for a drug which will produce satisfactory sedation with minimal side effects.

One other type of sedative compound is of interest for preoperative preparation. Glutethimide (Doriden) (2-ethyl-2-phenylglutarimide), a non-barbiturate drug, apparently is valuable in patients with insomnia, and has been suggested for sedation in the preoperative patient. Clinical reports concerning this drug are somewhat at variance(9). In our own clinic a doubleblind study was undertaken to determine the sedative action of this drug in preoperative male patients. Glutethimide, 500 mg., was given at bedtime the night before operation and 1,000 mg. were administered (orally) one to two hours preoperatively (table 1). In a second group of patients promethazine, 50 mg., was administered with the preoperative dose of glutethimide (table 2). In all patients the anticholinergic drug, atropine, was also prescribed: it is not believed to possess any sedative properties. Three residents in anesthesia evaluated the status of the patients just before anesthesia was induced. Perusal of the tables indicates no significant increase in sedative effects in those patients who received glutethimide. In the doses administered, glutethimide in this study was not judged to be an effective sedative for preoperative use.

No description of changing concepts in preoperative medication would be complete without reference to the utilization of synthetic anticholinergic drugs. As a substitute for atropine or scopolamine, several of these compounds, such as methantheline

Table 2

Effects of	Glutethimide in Combin Promethazine 158 Patients	
	Glutethimide Plus	Placebo Plus
	Promethazine	Promethazine
	93 Patients	65 Patients
Wide awake	38%	49%
Apprehensive	23	26
Alert	21	33
Drowsy	12	6
Asleep	4	0
Calm	60	50

bromide (Banthine) and oxyphenonium (Antrenyl) have been tested clinically. None has proved superior to atropine or scopolamine in adequate dosage⁽¹⁰⁾, except that oxyphenonium apparently is metametabolized more slowly in the body and therefore has a longer length of action⁽¹¹⁾.

Comment

It appears that we are at a crossroads with respect to preoperative medication. Greater facility in the induction and maintenance of anesthesia have reduced the necessity for the patient preoperatively to be drugged to a state of marked cerebral depression, often unfortunately with associated respiratory and cardiovascular depression. The patient deserves the initiation a calm, serene attitude free from anxiety and apprehension: the anesthetist would welcome a degree of somnolence light enough for the patient to be aroused and engaged in conversation. In the interest of both parties, the premedicant drugs should not depress the responses of the vital functions of respiration and circulation.

The drug or combination of drugs which will provide this millennium has yet to be found. New avenues of approach have been opened up recently and are being explored. The older regimens should not be cast off completely until one can be certain, through careful and extensive double-blind studies, that new suggestions are effective without inducing deleterious side actions. Clinical impressions alone will not provide the answers.

At all times one should bear in mind that preoperative medication is only as valuable as its individual application. Choice and dosage of drug must be determined on a patient-to-patient basis: general principles should be sufficiently broad to allow wide adaptability. This basic concept cannot be lost in the search for new techniques of premedication.

References

- Cohen, E. N., and Beecher, H. K.: Narcotics in Preanesthetic Medication: A Controlled Study, J.A.M.A., 147:1664-1668 (Dec. 22) 1961.
- Lasagna, L., von Felsinger, and J. M., Beecher, H. K.: Drug-induced Mood Changes in Man, J.A.M.A. 167:1006-1020 (March 19) 1955.
- Eckenhoff, J. E., Helrich, M.: Study of Narcotics and Sedatives for Use in Preanesthetic Medication, J.A.M.A. 167:415-422 (May 24) 1958.
- Berger, F. M.: The Chemistry and Mode of Action of Tranquilizing Drugs, Ann. New York Acad. Sc. 67:685-700 (May) 1957.
- Stephen, C. R.: Bourgeois-Gavardin, M., and Martin, R. C.: Preoperative, Preoperative and Postoperative Sedation with Reserpine, Ann. New York Acad. Sc. 61:236-249 (April) 1955.
- (a) Dyrberg, V., and Johansen, S.: Chlorpromazine in Preoperative Medication, Proc. Scandinav. Soc. Anes., 21-24, February, 1957.
 (b). Moore, D. C., and Bridenbough, L. D.: Chlorpromazine: A Report of One Death and Eight Near Fatalities Following Its use in Con-

- junction with Spinal, Epidural, and Celiac Plexus Block, Surgery 40:543 (Sept.) 1956. (c) Stephen, C. R., Dent, S., and Bourgeois-Gavardin, M.: Control of Nausea and Vomiting with Cblorpromazine, A.M.A. Arch. Int. Med. 96:794-798 (Dec.) 1955.
- Hopkin, D. A. B., Hunter, D., and Jones, C. M.: Promethazine and Pethidine In Anaesthesia: A New Approach to Pre-anaesthetic Medication, Anaesthesia 12:276-281 (July) 1957.
- Millar, R. A.: Promethazine and the Circulatory Response to Tilting, Canad. Anaes. Soc. J. 4:346-370 (Oct.) 1957
- (a) Abbas, T. M.: Clinical Trail of Glutethimide in Labour, Brit. M. J. 1:563-566 (March 9) 1957.
 (b) Branch. D. R., and Pastroello, R. R.: Use of Glutethimide for Preoperative Medication in Children, New England J. Med. 267:125-127 (July 18) 1957.
- Wyant, G. M., and Dobkin, A. B.: Further Studies of Antisialogogue Drugs in Man, Anaesthesia 13:173-178 (April) 1958.
- Stephen, C. R., Bowers, M. A., Nowill, W. K., and Martin, R. C.: Anticholinergic Drugs in Preanestbetic Medication, Anesthesiology 17:303-313 (March) 1956.

Problems in Maintenance of the Airway

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Of all the anesthesiologist's functions, maintenance of an adequate airway is the most important. Oxygen is the most essential element for maintenance of life, and yet it is the one which the body is least able to store in reserve. Anoxia and interference with the expulsion of carbon dioxide rapidly produce physiologic changes in the organism which, in turn, produce irreversible pathologic changes, if not corrected immediately.

It behooves the anesthesiologist to maintain a normal transport system in the patient he has rendered defenseless, and his responsibility does not terminate until the patient has regained full control of his own defense mechanisms. Constant vigilance is mandatory, and the first moment of complacency or inattentiveness to the patient's respiration, breath sounds, and exchange can well set the stage for respiratory obstruction.

Respiratory obstruction is the most common complication of depressed states⁽¹⁾. Cullen states that 90 per cent is a conservative estimate for deaths under anesthesia due to improper management of the airways⁽²⁾. A patent airway is a prerequisite for topical, infiltration, regional, and spinal anesthesia as well as for general anesthe-

sia. Obstruction of the airway has the same lethal potentialities in medical problems on the ward, and is more likely to go unnoticed or be treated with sedatives and narcotics in an attempt to allay the restlessness resulting from anoxia and hypercapnia.

Anoxia and hypercapnia are not the only undesirable effects of an inadequate airway. An obstructed airway makes breathing more difficult, tiring the respiratory muscles, increasing the oxygen requirements even more, and leaving the patient less capable of tolerating surgery and the post-operative period^(2,3). Laminar airflow is converted to turbulent airflow, thus increasing the work of breathing. Altered ventilation-perfusion ratios lessen the effectiveness of oxygen therapy⁽⁴⁾.

Obtaining and maintaining the desired plane of anesthesia is more difficult, with a resulting loss of control. The induction period is prolonged, again increasing the oxygen requirement as well as the risk of aspiration to add to the existing obstruction⁽⁵⁾. It is more difficult to reduce excessive levels of anesthesia. Relaxation is poor, with tense rectus muscles and increased diaphragmatic action. Increasing the level of anesthesia in order to gain more relaxation can prove disastrous. The intracranial pressure increases and other undesirable metabolic changes develop.

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This discussion will be limited to airway obstruction occurring at the beginning of, developing during, or resulting from anesthesia and/or surgical procedures.

Defense Mechanisms

The body is endowed, in the normal conscious state, with certain vital protective mechanisms to maintain the patency of the airway⁽⁶⁾. These self-cleansing mechanisms are obtunded at varying levels of anesthesia and are also interfered with or abolished by depression of the central nervous system from any cause⁽⁷⁾; drug intoxication, debility, or paralysis of either sensory or motor nerves⁽⁸⁾.

Swallowing is one such protective mechanism in that it prevents the accumulation of saliva. Salivary secretions normally amount to 1000-1500 cc. per 24 hours (**), and these secretions must be decreased by proper premedication if the normal protective functions are abolished. Swallowing is lost in upper plane I.

The larynx serves admirably by allowing the entrance and exit of air and at the same time by preventing foreign material from entering the tracheobronchial tree. The laryngeal reflex is overactive in the lighter planes of anesthesia, and is abolished in lower plane II or upper plane III. The overactivity of the laryngeal reflex in the lighter planes can lead to laryngospasm, at which time a protective function is converted into a real obstructive problem of its own.

Expulsion of foreign material from the tracheobronchial tree is accomplished by the cough reflex, ciliary action, and the peristaltic motion in the bronchioles (9). Cough is most commonly initiated by stimulation of the afferent nerve endings at the bifurcation of the trachea, in the laryngeal mucosa, and also by excitation of vagal afferents in the lung or pleural nerve endings. Cough disappears in plane I.

Ciliary action is mainly responsible for the moving of nasal and sinus secretions toward the nostrils. Ciliated epithelium is found in the nasal passages, sinuses, nasopharynx, the lower portion of the vestibule of the larynx, and the tracheobronchial tree down to the respiratory bronchioles. There the ciliated columnar cells change to cuboidal or flattened cells. Ciliary action is depressed by general anesthesia and by sedatives (6.9). The role of bronchiolar peristal-

sis is to assist the movement of foreign material towards the larger portions of the bronchial tree. It is said to be decreased in bronchiectasis and by morphine. Goblet, mucus, and serous cells also play a role in maintaining the airway, but these are depressed by premedication.

Pathologic Physiology of Obstruction

In respiratory obstruction, hypoventilation is the first of a series of developments. The alveolar ventilation falls as the respiratory minute volume decreases, with a resulting decrease in alveolar oxygen tension, a decrease in the oxygen saturation, and acidosis. There is an alteration of either the total or regional ventilation-perfusion ratios, depending on the location of the obstruction.

Acidosis develops by two different mechanisms. First, there is a respiratory acidosis resulting from the increase in free carbonic acid. If the anoxemia is severe, a metabolic acidosis also results, owing to an increase in lactic acid. There is insufficient oxygen to metabolize lactic acid by oxidation and resynthesis to glycogen. The potassium level increases. Cardiac muscle is incapable of developing any significant oxygen debt, in contrast to skeletal muscle (9). In both types of acidosis the lowered pH serves as a powerful stimulus to the respiratory center, which, in turn, increases pulmonary ventilation in an effort to lower the carbon dioxide blood tension. This is ineffectual proportional to the degree and persistence of the obstruction. Likewise administration of oxygen cannot correct the hypercapnia nor the accompanying respiratory acidosis. If it can be gotten past the point of obstruction it will help to alleviate the anoxemia, enable the respiratory center to withstand the increased carbon dioxide tension and lower the lactic acidosis (10). If the ventilation-perfusion ratios are altered, however, oxygen therapy will be less effective.

A point of crisis is reached at which the increasing carbon dioxide tension no longer stimulates the respiratory center, and breathing effort decreases. The blood changes worsen, and the respiratory center is then actually depressed. At this point a vicious, fulminating, and self-perpetuating cycle is in action, which may terminate abruptly and fatally. The concentration of carbon dioxide at which this crisis occurs

will be lowered in the presence of any existent respiratory center depression, whether from progressive anoxemia, acidemia, or

sedation(10).

The combined effects of anoxemia and hypercapnia on the cardiovascular system result first in a marked slowing of the heart. This initial bradycardia is explained by Marey's law, largely as a secondary effect of the hypertension which follows the action of anoxia and hypercapnia upon the vasoconstrictor center⁽⁹⁾. Later the blood pressure drops and the pulse increases, owing to failure of the heart as anoxemia progresses.

Causes of Obstruction and Their Alleviation

In the face of complete respiratory obstruction, prompt and effective treatment is of dire importance to prevent asphyxia. The onset of a partial obstruction may be more insidious and therefore less quickly recognized(3). The signs of respiratory obstruction are (1) failure of the chest to expand anteriorly, laterally, and posteriorly in its usual manner; (2) retraction of the supraclavicular, suprasternal, intercostal, and upper regions of the chest on inspiration; (3) noisy respirations from turbulent airflow; (4) minimal or absent tidal volume; (5) excessive diaphragmatic activity; (6) prolonged inspiration or expiration, depending upon the type of obstruction present; (7) bradycardia with hypertension; (8) dark blood in the operative field; (9) poor relaxation; (10) perspiration; (11) pupillary dilatation; (12) flattening of the electroencephalogram, and (13) cyanosis. Cyanosis is a late feature and its absence means nothing in ruling out airway obstruction, particularly in patients with low hemoglobin values. Likewise, noisy respirations mean obstructed respirations, but quiet respirations do not rule out obstruction, particularly when respirations are depressed. In contrast to respiratory depression, there is increased effort with decreased exchange in obstruction.

Full lips, especially in the edentulous or in the elderly patient with shrunken mandibles, can cause an expiratory obstruction characterized by a loud, low-pitched, rough, fluttery expiratory sound⁽²⁾. Other obstructions of the mouth include edema of the tongue, infections, macroglossia, trauma, micrognathia, tumors, facial scars, surgical

drapes, hands, and instruments. Unless the nasotracheal route is accessible, tracheotomy may be mandatory, depending upon the degree of oral obstruction present.

The most common type of obstruction seen in the oropharynx is that caused by relaxation of the jaw and tongue, and is characterized by a rough, irregular, stuttery noise on inspiration or no noise at all if the obstruction is complete. Extension of the head with the chin pointing toward the ceiling and the jaw supported in an anterior position will frequently relieve this condition. In patients with nasal or nasopharyngeal obstruction the airway is improved by holding the mouth open. A pharyngeal airway of the proper size may be employed if the patient is not too lightly anesthetized. An improperly fitted airway may aggravate the obstruction. One which is too small will bury its tip into the base of the tongue, while one which is too long may extend too far into the hypopharynx. Tumors, infections such as peritonsillar and retropharyngeal abscesses, tonsillar hypertrophy, and large foreign bodies are other causes of oropharyngeal obstruction(11).

Obstruction at the glottis can be brought about by tumors (12), infections, trauma, and foreign bodies such as dentures, food particles and gum. The loose areolar tissue in the supraglottic region is more subject to edema, which can cause obstruction (13). Granuloma of the vocal cords is a late complication of endotracheal techniques, and is quite uncommon with the use of plastic endotracheal tubes. The obstruction seen after thyroidectomy is most commonly caused by (1) a hematoma beneath the pre-tracheal muscles, (2) recurrent nerve injury, (3) laryngeal edema, or (4) tracheal collapse, particularly with intrathoracic goiters (14).

The protective laryngeal reflex has been mentioned previously. Laryngeal spasm is accomplished by one of four mechanisms, separately or combined. These are (1) midadduction of the true vocal cords, (2) apposition of the ventricular ligaments, (3) the sphincter-like action of the aryepiglottic folds, and (4) impaction of the epiglottis into the larynx. The first mechanism prevents inspiration but will allow expiration, owing to the dome-shaped structure when the true cords are approximated. This type of spasm, when only partial, produces a high-pitched crowing tone. When com-

plete, it results in inability to inflate the thorax. Mid-adduction of the ventricular ligaments embarrasses expiration. Apposition of the aryepiglottic folds, which act as a sphincter, produces an even more pronounced degree of laryngeal spasm. The fourth mechanism by which the larynx is obstructed is impaction of the epiglottis in the larynx by muscular relaxation of the tongue. Drawing the tongue forward relieves this condition⁽¹⁵⁾.

Laryngeal spasm can be caused by direct or reflex stimulation⁽¹⁶⁾. Foreign material, secretions, blood, mucus, vomitus, and increasing concentrations of ether and soda lime dust are all listed as causes of direct initiation. Local stimulation can also follow trauma from airways, laryngoscopes, suction tips, and endotracheal tubes. Reflex stimulation can follow traction on the gall-bladder, stomach, spleen, mesentery, trachea, rectum, vagina, periosteum, celiac and pelvic plexuses. Parasympathetic stimulation as seen with ultrashort-acting barbiturates or cyclopropane enhances the laryngeal reflex⁽¹⁷⁾.

Obviously prophylaxis is the best treatment. Adequate oxygenation is the most important factor in the prevention as well as the treatment of laryngospasm(16,18). Anesthetic concentrations especially ether, should be increased gradually, and an intermediate agent such as nitrous oxide or ethylene should be interposed between an ultrashort-acting barbiturate and ether. Premedication with one of the anticholinergic drugs at the right time and in the proper dosage, should be given to decrease vagal tone. Keep the local simulation, mentioned before, to a minimum and avoid painful stimulation until surgical planes of anesthesia are reached. If vomiting occurs during induction, place the patient in Trendelenburg position, aspirate the airway, and allow the patient to cough before continuing. Endotracheal intubation should be carried out for surgery where reflex stimulation is expected or where contamination of the respiratory tract by blood, secretions, a full stomach, intestinal obstruction, bronchiectasis, or a lung abscess is anticipated. Prostigmin should always be preceded by an anticholinergic agent to minimize the muscarinic actions of the former. Care should be taken on extubation to make sure have been previously that secretions

cleared. These are all measures for circumventing laryngeal spasm.

Once laryngeal spasm has occurred, what measures should be undertaken? Oxygen should be given by positive pressure immediately. Determine the cause. The concentration of ether should be lowered if this is thought to be the etiologic factor. If the spasm is reflex and appears in light anesthesia, the concentration of ether or other agent may be increased and the surgical stimulation delayed until a deeper plane is reached. The ultrashort-acting barbiturates should be discontinued if they are thought to be related to the laryngospasm. An analgesic should be used with the thiobarbiturates, since they are mainly hypnotics when employed in safe doses.

Muscle relaxants, particularly succinylcholine, have completely altered the picture of laryngospasm. Small doses of succinylcholine, 10 to 20 mg., given intravenously or larger doses given intramuscularly, if a vein is not immediately available, will usually suffice. If laryngospasm is persistent recurrent. endotracheal intubation should be performed. If the spasm is overcome, however, endotracheal intubation should be deferred until the patient has been properly oxygenated. If the above procedures are unsuccessful, transtracheal resuscitation(19) or a tracheotomy should be done with dispatch at the first sign of circulatory failure.

Subglottic edema is an unusual complication following intubation, and is characterized by the onset, 24 to 48 hours later, of acute respiratory obstruction, predominately expiratory in nature. The clinical picture is that of laryngeal edema, but upon direct inspection the epiglottis, glottic chink, and larynx appear normal. On bronchoscopic examination the membrane is observed, usually attached to the anterior aspect of the cricothyroid region, It produces obstruction by reducing the diameter of the airway, by impeding expiration with its flap-like structure, and by causing reflex adduction of the cords when the medial portion of the membrane is unattached. The subglottic area represents the narrowest portion of the larynx, and the cricoid cartilage forms a complete rigid ring(20). The loosely attached mucosa and the looseness and vascularity of the submucosa predispose this region to edema. Trauma to the

subglottic region is thought to be the precipitating factor. The anterior aspect is the point at which the curved endotracheal tube or stylet impinges. Oversized endotracheal tubes and cuffs are more likely to produce subglottic edema(21). In all 3 cases reported by Etsten⁽²²⁾, metal stylets and Magill rubber endotracheal tubes with cuffs had been used. The cuffs were not inflated, because of the snug fit. Portex plastic tubes are thought to be superior in that they mold at body temperature and thus lessen pressure at localized points(18). Immediate laryngoscopy and suction bronchoscopy to remove the membrane are the methods of choice for the diagnosis and the treatment of subglottic edema.

The causes of obstruction in the trachea and larger bronchi are foreign bodies or foreign material, blood, mucus, pus, gastric secretions, sucus entericus and fecal material following regurgitation and aspiration, tumors, and tracheal collapse from tracheal cartilages weakened by extrinsic pressure. Tracheal stenosis creates a very difficult problem in that oxygen must be passed through a narrowed diameter which is easily obstructed by secretions in the absence of the cough reflex(23). The surgical intervention for stenosis or tracheal trauma(24) disrupts the continuity of the tracheobronchial tree and a by-pass must be created to one or both mainstem bronchi.

Aspiration is a very common cause of airway obstruction, and general anesthesia should be avoided when it is known or suspected that the stomach is not empty. Intubation should be carried out under topical anesthesia prior to the induction of general anesthesia, when gastric contents are in question. Most of the literature gives little or no attention to the problem of aspiration in obstetric patients under general anesthesia. Here the anesthesia is more likely to be "in and out" with varying levels of anesthesia. Too many obstetric patients come in with a history of recent ingestion(16), much of which could be avoided with proper counseling in the last trimester of pregnancy. Many patients feel that they must sustain themselves for the ordeal of labor; or they have been on dietary restrictions and feel that the rupture of the membranes, vaginal show, or the onset of mild labor pains terminates the dietary limitations and allows them to celebrate with a large meal.

The definitive treatment of aspiration consists of putting the patient in the Trendelenburg position, removing the mask, turning the head to one side, and suctioning the airway. Endotracheal intubation and bronchoscopy are other means of clearing the tracheobronchial tree. Coughing, initiated by the suction catheter, is also effective in removing the foreign material.

Bronchospasm is characterized by an active and prolonged expiration with wheezing and rales, and it is frequently seen in asthmatic persons. It may represent a reaction to one of the drugs given before or during surgery, or may follow vagal stimulation. Soda lime dust is a common offender. The offending agent should be eliminated, if known, and cyclopropane and the ultrashort-acting barbiturates avoided if thought to be incriminated. Aminophylline, ephedrine, Isuprel, and the antihistamines are frequently effective, and ether serves as a good agent to counteract the bronchoconstriction, because of the resulting sympathoadrenal discharge. Alveolar exudation and pulmonary edema present the dual problem of supplying oxygen under positive pressure and, at the same time, removing secretions which impede gaseous exchange (8,25). Care must be taken to prevent overloading the patient with fluids, particularly in the pediatric age group.

We must also look for iatrogenic causes for airway obstruction. In this category would come stiff valves, narrow apertures in connectors or tubes, wet or fine mesh soda lime, long tubes, kinked tubes, and empty or full breathing bags. Overinflated cuffs or a cuff which has slipped over the bevel of the tube may cause a ball-valve type of obstruction on expiration. Care must also be taken not to advance the tube into a mainstem bronchus.

Summary

The most important responsibility of the anesthesiologist is to maintain a patent airway. Respiratory obstruction is a self-perpetuating complication which does not lend itself to spontaneous correction. Procrastination and conservatism are fraught with great danger in the management of an obstructed airway.

References

- American Medical Association: Fundamentals of Anesthesia, ed. 3, Philadelphia, W. B. Saunders Company, 1954.
- Cullen, S. C.: Anesthesia in General Practice, ed. 4, Chicago Year Book Publishers, 1954.

- Sadove, M. S., Gittelson, L. A., Wyant, G. M., and Holinger, P. H.: The Maintenance of An Efficient Tracheo-bronchial Airway, Am. Pract. & Digest Treat. 5:11-16 (Jan.) 1954.
- Comroe, J. H., Jr.: The Lung. Clinical Physiology and Pulmonary Function Tests, Chicago, The Year Book Publishers, 1955.
- Berson, W., and Adriani, J.: "Silent" Regurgitation and Aspiration During Anesthesia, Anesthesiology 15:644-649 (Nov.) 1954.
- Vandam, L. D.: The Functional Anatomy of The Lung, Anesthesiology 13:130-141 (March) 1952.
- Taylor, G. W., and Austin, G. M.: Treatment of Pulmonary Complications in Neurosurgical Patients by Tracheotomy, A.M.A. Arch. Otolaryng. 53:386-392 (April) 1951.
- Galloway, T. C., and Elsen, J.: Bulbar Poliomyelitis: A Respiratory Problem, Laryngoscope 61:548-564 (June) 1951.
- Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 4, Baltimore, Williams and Wilkins Company, 1945.
- Gray, J. S.: The Physiology of Respiratory Obstruction. Ann. Otol. Rhin. & Laryng. 59:72-77 (March) 1950.
- Weller, W. A.: Obstruction of the Air Passages, Ann. Otol. Rhin. & Laryng. 51:1080-1093 (Dec.) 1952.
- Finer, M. J., and Lhotka, F. M.: An Unusual Airway Obstruction; A Case Report. Anesthesiology 12:666-667 (Sept.) 1951
- Snyder, J. J., and Gants, R. T.: Respiratory Obstruction at the Glottic Level, Anesthesiology 14:195-201 (March) 1953

- Lahey, F. H., and Hoover, W. B.: Tracheotomy After Thyroidectomy, Ann. Surg. 133:65-76 (Jan.) 1951.
- Burstein, C. L.: Fundamental Considerations in Anesthesia, New York, MacMillan Company. 1949.
- Guedel, A. E.: Inhalation Anesthesia; A Fundamental Guide, ed. 2, New York, MacMillan Company, 1951.
- Adriani, J.: Techniques and Procedures of Anesthesia, Charles C. Thomas, Springfield, Illinois. 1947.
- Stephen, C. R.: Elements of Pediatric Anesthesia, Springfield, Charles C. Thomas, 1954
- Jacoby, J. J., and others: Transtracheal Resuscitation, J.A.M.A. 162:625-628 (Oct. 13) 1956.
- Eckenhoff, J. E.: Some Anatomic Considerations of the Infant Larynx Influencing Endotracheal Anesthesia, Anesthesiology 12:401-410 (July) 1951.
- Flagg, P. J.: Incidence and Control of Trauma Accompanying Endotracheal Anesthesia, A.M.A. Arch. Otolaryng. 53:439-445 (April) 1951.
- Etsten, B., and Mahler, D.: Subglottic Membrane, A Complication of Endotracheal Intubation, New England J. Med. 245:957-960 (Dec. 20) 1951.
- Stephen, C. R., Nowill, W. K., and Sealy, W. C.: Problems of Anesthesia in Tracheal Reconstruction. Anesthesiology 15:206:208 (March) 1954.
- Furman, C.: Ruptured Right Bronchus, Anesthesiology 15:704-705 (Nov.) 1954.
- Haddy, F. J., Campbell, G. S., and Visscher, M. B.: Pulmonary Vascular Pressures in Relation to Edema Production by Airway Resistance and Piethora in Dogs, Am. J. Physiol. 161:336-341 (May) 1950.

Influence of Antibiotic Treatment On Roentgenologic Aspects of Mastoid Disease

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Roentgenograms play an important role in the diagnosis of mastoid disease and are often the guideposts to treatment. The skillful use of appropriate antibiotics cures most patients, but a significant number respond only partially. In this group, the clinical picture and the x-ray picture are modified to such a degree that the usual criteria of evaluation no longer are applicable.

The early roentgen changes in untreated acute mastoiditis are clear cut. They are as follows:

- 1. Clouding of the middle ear
- 2. Clouding of the air cells
- 3. Clouding of the antrum
- 4. Fuzziness of the cellular partitions
- 5. Increased visualization of the sinus plate
- 6. Increased visualization of the semicircula canals

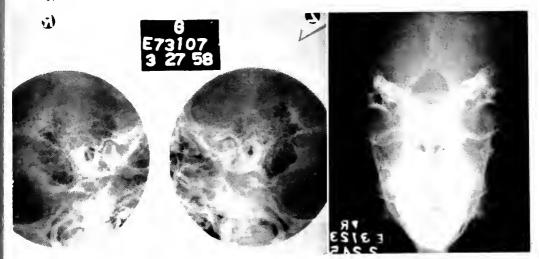
From the Duke University Medical Center, Durham, North Carolina,

7. Clouding of the hypotympanic zone
The above changes progress and after

five or six days are pronounced. Bone detail is lost and the cells coalesce into a large amorphorus density of the quality of soft tissue. This state represents the so-called surgical mastoid.

Effective treatment results in a reversal of the above changes, and within a two-week period the x-ray picture usually has returned to normal (fig. 1).

A significant number of patients, however, show both clinical and x-ray aberrations induced by antibiotic treatment, and because of these differences, the usual criteria for assessing the patient and his roentgenograms are no longer valid. The infection is often attenuated but not eradicated. Thus an apparently well patient may continue to show roentgenographic abnormalities. Several patterns of change have been noted. There may be a persistence of diffuse cell clouding beyond the expected period, associated with all or some of the



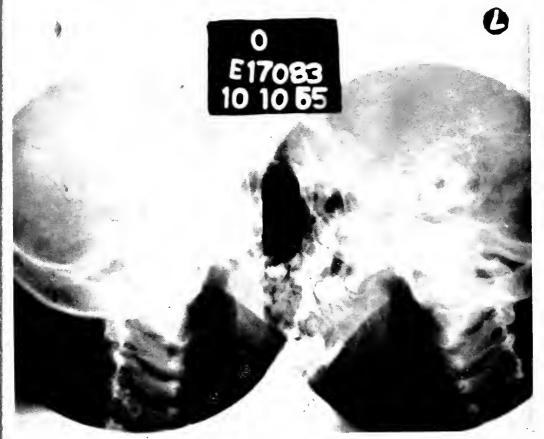


Fig. 2. The left side shows normal cells. On the right the cells are cloudy and the septa indistinct.



Fig. 3. The zygomatic septal breakdown is seen in the mastoid on the right side of the illustration.

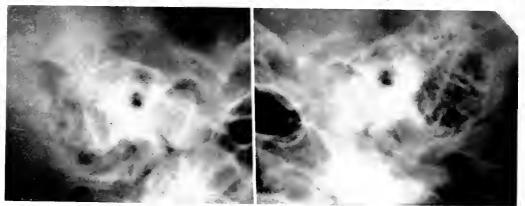


Fig. 4. The left side of the illustration shows focal destruction in the mid-portion of the sinus plate.

An absess was found at operation. Other cells are clear.

other changes enumerated above (fig. 2); or there may be focal destruction in the midst of complete clearing of all other signs. Under these circumstances the apparently well patients, if all treatment is discontinued, may experience mild or explosive recurrences of symptoms.

The focal changes represent the greatest challenge to the radiologist. Only a few cells may be involved. The zygomatic group will break down, while all the other cells become clear (fig. 3). This situation may lead to brain absess or meningitis. Perisinus cellular necrosis is apt to take place in an otherwise normal mastoid and lead to thrombosis of the lateral sinus (fig. 4). Only the attic cells at times remain infected and serious intracranial complications may occur. Each of the circumstances detailed above produces subtle changes that are easily overlooked.

Rigid criteria must be applied in the interpretation of mastoid films of patients under antibiotic treatment. Persistence of cellular clouding and failure of the intercellular septa to regain fine definition constitute a warning signal that the patient may not be well regardless of the clinical picture. A large number of such patients were found at operation to have nonpurulent granulomatous changes in the mucous membrances as well as marked softening of the bony partitions. In essence, the infection was present in an attenuated state.

As a corollary to the above principle, it must be emphasized that the failure of the roentgenograms to return to normal does not in itself indicate further medical or surgical treatment. Many patients eventually are completely cured despite the persistence of x-ray changes for periods of several months.

Unfortunately, no dogmatic criteria can be set as to what constitutes a cure. Close collaboration between clinician and radiologist is mandatory. Moreover, the patient must be expertly guided through the period of evaluation without being lulled into a false sense of security or unjustly alarmed. Conclusions

1. Antibiotic therapy may alter the x-ray patterns in mastoiditis.

2. Cell clouding and bone haziness may

persist for weeks or months.

3. Focal necrosis of cells may lead to intracranial complications.

A Controlled Clinical Study Using the New Oral Diuretic Benzydroflumethiazide (Naturetin (R)).

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This report summarizes our observations on the use of a new oral diuretic for the management of edema in a group of ambulatory patients attending a low-cost outpatient department. The recently available drug is benzydroflumethiazide (Naturetin), a benzothiodiazine derivative differing from dihydroflumethiazide and chlorothiazide by the addition of a benzyl group to the former and a benzyl and trifluoro group to the latter⁽¹⁾.

Material

Eighteen patients are included in this report: 12 Negro (four males and 8 females) and 6 white (2 males and 4 females) (fig. 1). The ages ranged from 31 to 70 years, with an average of 52.5 years. Their primary basis for the development of edema was as follows: 5 patients, hypertensive vascular disease; 4, arteriosclerotic heart disease; 7, hypertensive-arteriosclerotic heart disease; 1, diabetic vascular disease complicated by edema; and 1, rheumatic heart disease. The patients were chosen for the study from the population attending the general medical clinic. Once it was decided to conduct the study, patients were selected sequentially from the next series of patients with edema that were presented at the clinic. The sole clinical characteristic upon which selection was based was the existence of peripheral edema in an ambulatory individual. Any existing treatment program being used for the primary disease was not altered during the study. Eight patients were receiving a digitalis preparation and 6 patients with hypertension were receiving a ganglionic blocker, trimethidinium methosulfate. The dose of the ganglionic-blocking agent was reduced by half prior to the use of diuretics. Two patients with diabetes were taking insulin. Other concomitant medications included apresoline, phenobarbital, and Raudixin. There were 12 patients who had received diuretics prior to the study and 6 who had not.

The patients remained ambulatory throughout the period of observation and were usually seen at bi-weekly intervals,

TOTAL 18

NEGRO 12

MALE	FEMALE	MALE	FEMALE				
2	4	4	8				
ARTE	RIOSCLEROTIC RTENSIVE VAS	HEART DISE	EASE4				
HYPE	RTENSIVE -ART SEASE	ERIOSCLER	OTIC7				
RHE U KIMM	MATIC HEART ELSTIEL-WILS	ON	I				
]	Fig. 1. Character	ristics of pat	ients.				

WHITE 6

From the Department of Internal Medicine, Duke University Medical Center, Durham, North Carolina.

^{*}This study was supported in part by a grant from the E. R. Squibb Co., Inc. and in part by a grant from the Duke University Center for the Study of Aging.

Table 1

	The	Modified Latin	Square Desi	gn
Patients		Time Period 1	Time Period 2	Time Period 3
A		I	11	III
В		Ţ	ĪII	11
Ď		11	111	III
Ē		III	II	1
F		III	Ī	ÎΙ

Treatment Period I No Drug

 II 5 Mg. benzydroflumethiazide, twice daily
 III 500 Mg. chlorothiazide, twice daily

although some were seen weekly or monthly. Six patients who were started on the study did not finish; 5 patients did not keep return appointments and did not answer follow-up letters, and 1 patient with severe congestive heart failure was dropped from the series because of the obvious disadvantage of discontinuing diuretic medication during the control phase of the study.

Method

In the clinical evaluation of a new drug, the problems confronting the physician in effecting the appropriate control observation are well known. In order to reduce the number of interfering factors that might compromise the establishment of such a controlled program in a heterogeneous population of ambulatory patients, the Latin Square (table 1) was modified to fit the needs of this study⁽²⁾. This form of exper-

imental design consists of the assignment of 6 patients to a "Latin Square" comprising three time periods (periods 1, 2, and 3), and three test periods; a "no drug" control period (period I), a "new drug" period (period II) and an "old drug" period (period III).

Each patient goes through every test period. For a three period study there are six sequence variations, I II III, III I II, and so forth, exposing each test situation to the same variations in time. Each individual acts as his own control. Five hundred milligrams of chlorothiazide(3) given twice a day was used as the "control drug," and 5 mg. of benzydroflumethiazide given twice a day was the dose of the new drug. During the control period no diuretic was used. The test period to be used first was unknown until after the patient was selected for the study. The periods usually lasted four weeks, but if the patient became too uncomfortable without a diuretic during the control period, it was terminated after two weeks. The diets were estimated at the onset, but no effort was made to change or control them during the study other than to urge that they be kept constant. Seasonal variations were controlled by the nature of the experimental design—that is, just as many patients were off the drug during one season as there were patients taking the drug, tending to

Table 2. Summary of Patient Characteristics and measurements of weight, serum sodium, and serum potassium at the end of the time periods, with the individual differences noted during each drug period.

PATIENT A SECUENCE SEX	DEAGNOSIS		PERIOD I (CONTROL)		FERIOD 11 Benrydroflumethiazide						I-II Change on Benzydroflumethiazide			I-III Change on Chlorothiazide					
		DIGITALIS	Veight	Serum Na	Serum	Weight	Serum Na	Serum	Veight	Serum Sa	Serum K	Weight	Serum Sa	Serum	Weight	Serum	Seru		
c.s.	45 CF	1 11 111	Diabetes, HASHD	No	188.5	139	4.9	184.5	135	4.3	181.5	135	4.3		-4	-0.6	-7	-1	-0.1
J.M.	58 OH	1 111 11	ASHD	Yes	141	133	4.1	151.5	143	3.5	144.5	144	3.7	ø10.5	-11	-0.6	+3.5	•11	-0.4
A.C.	69 CF	II 1 III	ASED	Yea	138	139	5.6	132	139	5.1	132	136	4.2	-6		-0.3	-6	-1	-1.
J.L.	53 CH	II III I	RASED	Yes	160	145	5,1	150.5	139	4.4	152.5	141	4.2	-9.5	-6	-0.7	-7.5	-4	-0.
м.в.	33 CF	III II I	GAR	No	161	142	4.3	153.8	136	3.6	155.5	147	4.1	-7.2	-4	-0.7	5.5	•5	-0.2
K.H.	30 VF	III I 11	RED	Tes	116	144	4.7	113	138	3.7	113	136	4.1	-3	-6	-1.0	-3	-8	-0.6
1.M.	47 VP	I II 111	Diabeces	No	173.5	132	5.4						- }						
E.L.	3 CF	I III II	1	No.	119.5	139	4.1	172.5	133	4.4	169	140	4.3	-1	•1	-1.0	-4.5	+8	-1.
A.H.	63 CF	11 1 111	ASHD	Yes	108.5	141	4.1	101	136	3.9	120.5	145	3.8	-0.5	-3	-0.2	•1	•6	-0.
R.L.	63 NM	11 111 1	RASED	Yea	163	140	4.7	155	139	4.8	154.5	136	4.0	-7.5 -8	0	+0.8	-3	42	-0.
н.в.	70 WP	111 11 1	BASCVD,Osteoarthritis	No	145	145	3.7	142.5	146	4.1	160.5	145	3.7	-2.5	-1	•0.1	-8.5	-4	-0.
3.5.	c2 VP	111 1 11	DEZA	Tea	124	142	4.8	122	143	3.9	122	143	3.9	-2		-0.9	-4.5	0	-0.5
						- 1		- 1						.			-	.	-0.
P.1.	58 MH	2 11 111	8CVD	Но	169	141	3.7	264	139	3.7	169	141	3,8	-5	-2		. [. 1	+0.
E.L.	36 CF	1 111 11	GVB	Mo	119.5	139	4.1	119	135	3.9	120.5	145	3.8	-0,5	-3	.0.2	.1		-0.
A.B.	49 CF	11 1 111		No	171	144	3.9	170.5	137	3.9	172	142	3.8	-0.5	-7	.	.1	.2	-0.1
J.L.	57 CH	1	HCVD, Obesity ,	No	262	136	4.4	257.5	140	3.9	257	143	3.7	-4.5	+2	-0.5	-5	.5	-0.7
L.McG	65 CF		HASPD, Asthma	Yes	174.5	141	5.6	172.5	136	5.7	171	139	5.3	-2	-5	-0,1	-3.5	-2	-0.5
t.J.	50 Q+	111 1 11	HASHD, CAS	No	203,5	144	4.5	203	138	4.0	198	137	4.5	-0.5	- 1	-0.5	-5.5	-7	0

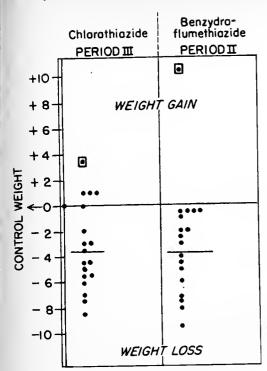


Fig. 2. Effect of drugs on weight loss.

minimize the effects of weather, crop rotation, and so forth, in this sampling of the rural population.

The patient's weight has been used as the sole experimental index to the status of the edema volume. Clinical comments were not used in evaluating the effectiveness or ineffectiveness of the diuretic therapy. The weight of the patient was recorded at each visit, and the weight for each test period was scored by using the value obtained on the last day of that period. The weight of the patient at the end of the control period was scored as the base-line "wet" weight to which weights after the drug periods were completed were to be compared. The weight loss effected for each drug program was calculated in that manner, thereby reducing the interaction of one drug period upon the other, and eliminating the effect of previous diuretic therapy upon the analysis of the present study.

Results

The results of the study are listed in table 2 and pictured in figures 2-4. The data obtained revealed that there was a significant weight loss (p.<.001) during both drug

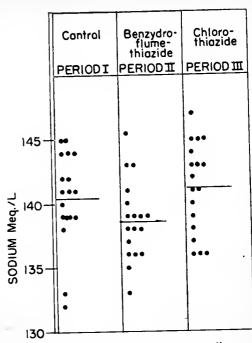


Fig. 3. Effect of the drugs on serum sodium.

phases. The mean weight loss caused by benzydroflumethiazide was 2.98 pounds and the loss due to chlorothiazide was 3.27 pounds (fig. 2). These values were not significantly different from one another. There was no significant difference due to drugs between the serum sodium (fig. 3) or serum potassium (fig. 4). Further analysis of the data showed no variation caused by the sequence in which the drugs were presented, and the analysis of error also showed no significant variation. There were some changes, however, due to the periods (seasonal changes) p<.05, but because of the structure of the experiment this change could have nothing to do with the drug effect and therefore would not alter the significance of the weight loss attributed to the drugs. It may be noted that while there was an almost uniform weight loss among the patients, one man, J. M., gained 10.5 pounds on benzydroflumethiazide and 3.5 pounds on chlorothiazide. This patient was in the recovery phase of acute heart failure and quite underweight. During the period of the study he had very little edema, but he regained his normal weight, going from 141 pounds (actually 134 pounds at the beginning of period I) to 151.5 pounds. His

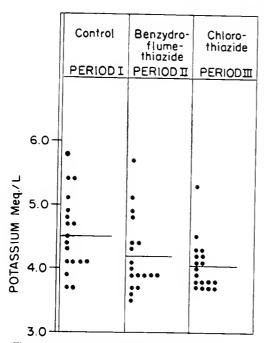


Fig. 4. Effect of the drugs on serum potassium.

weight has now stabilized at this level, and he is still relatively free of edema. He was the only patient included in whom the nutritional status was so severely disordered. Review of the values excluding this patient shows a mean weight loss of 3.77 pounds on benzydroflumethiazide and 3.67 pounds on chlorothiazide.

The patients who had received prior diuretic therapy showed a greater weight loss (-3.62 pounds) than the patients who

had never been treated with diuretics (-2.08 pounds). It should be noted that both drugs caused some lowering of blood pressure, which remained well controlled during the drug phases, at which time the doses of the ganglionic-blocking agent had been lowered to one-half of the previous treatment level. There were no side effects attributable to the drugs and no episodes of gout during the study. Uric acid determinations were not made. The white blood cell count and differential counts remained normal.

Summary

Benzydroflumethiazide, a new benzothiadiazine oral diuretic, was tested in the treatment of edema in a group of ambulatory patients in a low-cost out-patient department by the use of a modified Latin Square, an experimental design that allowed for the control of a heterogeneous patient sampling and control of the experimental environment. Benzydroflumethiazide produced a mean weight loss of 2.98 pounds and chlorothiazide a mean loss of 3.27 pounds without a significant change in the serum sodium or serum potassium attributable to either.

The authors wish to thank Dr. David M. Shaw of the Department of Sociology, Duke University, for his invaluable help in designing the study.

References

- Data made available by the Squibh Institute of Medical Research, New Brunswick, New Jersey.
- Edwards, A. L.: Experimental Design in Psychological Research, New York, Rinehart & Co., Inc., 1950.
- Ford, R. V., Moyer, J. H., Spurr, C. L.: Clinical and Laboratory Observations on Chlorothiazide (Diuril) A.M.A. Arch Int. Med. 100:582-596 (Oct.) 1957.
- Moyer, J. H.: Human Pharmacology of Thiazide Derivatives, J.A.M.A. 170:2048-2054 (Aug. 22) 1959.

What is the proper balance between teaching and research activities? This is an individual problem. Some individuals certainly will render their greatest contribution in research, others in teaching. Local conditions, including a school's resources and general administrative policies, also determine teaching assignments and research support. In general, however, it may be agreed that the interests and development of undergraduate students and thus of our future scientists and scholars demand a reasonable degree of exposure to the best scholars of the present. If so, academic faculty position must retain or recapture the ideal of a synthesis rather than a dichotomy of its two major responsibilities.—Nash, T. P., Jr.: Research and Teaching or Research Versus Teaching? Memphis M. J. 34:262 (July) 1959.



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Bitter Apple (Citrullus Colocynthis) Poisoning A Discussion of Its Use As An Abortifacient

ROMAN L. PATRICK, M.D.*
EDWARD N. WILLEY, M.D.
and
BERNARD F. FETTER, M.D.
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The history of bitter apple is well documented until recent times. It has been known as colocynth, bitter cucumber, and bitter gourd. The plant, Citrullus colocynthis, is a member of the melon family or Cucurbitaceue⁽¹⁾. It is native to the Mediterranean region, Western Asia, and Africa. The rind of the fruit is thick and yellow. The pulp is light and spongy and filled with seeds. In the Ebers papyrus, written about 1500 B.C., colocynth is mentioned in 30 out of 877 recipes⁽²⁾. Egyptian physicians were aware of it as a drastic purge. The fruit is also mentioned as a purge in the Bible (II Kings 4:38-41).

Other references to colocynth of historical interest are numerous⁽³⁾. In *Lancet* of 1868 we find an interesting clinical and pathological presentation of a case of colocynth intoxication⁽⁴⁾. The patient had vomiting and diarrhea terminating fatally in 48 hours.

Roe(5) has presented one of the most thorough descriptions of the clinical course of a case of colocynth intoxication. His patient, a 25 year old woman, took 75 grains in powder. Vomiting began in about one hour. Severe diarrhea and vomiting continued until she was exhausted and dehydrated. After 24 hours abdominal pain and diarrhea persisted, but the patient tolerated oral feeding. She had an uneventful recovery. The author commented on the uncertain action of the drug and the wide range of toxic symptoms. Apparently a fatal dose is a dram (4 Gm.). "In most cases it has been taken as an abortifacient."(5) In doses of 30 to 60 grains toxic effects include shooting pains in the limbs, muscular weakness, drowsiness, abundant salivation, and signs of dehydration. Larger

doses give rise to trismus and marked tonic contraction of the limbs. "Nearly all the cases wherein doses of 110 gr. and over were taken have ended fatally, and in these cases the central nervous system is usually affected; giddiness, tinnitus with increasing deafness, and, in one case, partial facial paralysis have been noted. With regard to postmortem changes, in some cases nothing abnormal has been found." (5) Von Oettingger (6), in listing the symptoms of intoxication, adds circulatory disturbances to the foregoing, as well as "irritation of the kidney resulting first in polyuria and later oliguria."

Rolfe⁽⁷⁾ reported a case marked by vomiting, diarrhea, and shock. The patient recovered after treatment with morphine and digitalis. Abortion did not occur.

Standard textbooks of toxicology base their statements upon these authors (8).

Chemistry of Colocynth:

In 1858 Walz⁽⁹⁾ wrote that colocynth contains a bitter glucoside designated "colocynthin," to which he ascribed the improbable formula C₅₆H₈₄O₂₃. This formula has even been incorporated in contemporary literature(10). Walz further stated that there was an amorphous resin which received the name "colocynthein" and a tasteless crystalline compound, "colocynthitin." Henke(11) was unable to demonstrate the glucosidic character of the yellow amorphous powder which Walz termed "colocynthin." Other authors (12) elaborated additional characteristics of the various fractions; however, Power⁽¹³⁾ states that there is no evidence that any of these products were pure or homogeneous substances and that the comparison of them was chiefly related to certain color reactions which are by no means specific. He adds that it is quite safe to assume that the products referred to were very indefinite mixtures.

Power and associates (13) performed the most nearly complete and detailed analysis

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of the fruit. They isolated the following: From the alcoholic extract, water soluble substances included a dihydric alcohol, $C_{22}\,H_{36}O_2\,(OH)_2$; an amorphous alkaloidal principle, which is a very weak base and from which no crystalline derivative could be prepared; a quantity of inorganic salts; a little sugar: and a very small amount of an amorphous glucosidic substance. The water insoluble fraction consisted chiefly of resinous material; alpha-elaterin; hentriacontane, $C_{31}H_{64}$; a phytosterol, $C_{27}H_{46}O$; and a mixture of fatty acids.

The seeds contained traces of the alkaloidal principle, a small amount of enzyme which hydrolyzed beta—glucosides, and a

quantity of fatty oils.

Power also determined that the purgative action is due to at least two principles, one alkaloidal and the other unidentifiable but present in both the ether and chloroform extracts of the resin.

Two cases will be presented and their relationships to the foregoing discussed material presented above.

Case Reports

Case 1

An 18 year old Negro woman who reportedly had given birth to an illegitimate child approximately one year previously was brought to the emergency room at 1:50 A.M. by a Negro woman who purported to be her grandmother. She was again pregnant. Algor and livor mortis without rigor mortis were present. Two weeks after necropsy the State Police informed us that according to her family she had come to Durham the day before her death for the express purpose of undergoing an abortion. After her arrival on the afternoon of August 27 no details of her activities are known. According to her grandmother, she had collapsed at 12:30 A.M. in the bathroom. Despite the suspicious nature of the death, the coroner disclaimed interest in the case. Authorization for the necropsy was obtained from a parent.

At antopsy the livores mortis were red-purple and posterior. Rigor mortis was complete. There were no external abnormalities. Striae albicantae and diastasis recti were noted. The upper margin of the uterine fundus was 18 cm. above the pubis. The abdominal and thoracic cavities were normal; the serous surfaces were dry. The heart was of normal size and appearance; the coronary arteries were patent, with only focal superficial lipid deposits in the intima. The aorta also had a few scattered longitudinal lipid streaks. The heart blood was liquid and was sterile both in anaerobic and aerobic cultures. Centrifugation showed no hemolysis and the postmortem hematocrit was 40 per cent,

without abnormal cellular sediment. Spectroscopy revealed only oxyhemoglobin. The upper respiratory tract was patent, and the neck structures were intact. The lungs were crepitant and the bronchi and arteries were patent and entirely normal. The veins in the pelvis, legs, and feet were free of thrombi. The thymus weighed 50 Gm. but did not compress the trachea or otherwise appear unusual. The abdominal organs appeared normal except for congestion of the spleen and liver. The oropharynx and esophagus were normal.

From the stomach and proximal jejunum about 550 cc. of viscid brown granular material was collected for toxicologic analysis. The enteric contents emitted a pungent odor somewhat resembling vanilla extract. Although compared with all the pharmacologic vehicles in the hospital and with many volatile poisons, it was not identified. The entire bowel from mid-jejunum downward was nearly free of contents except for mucus; the complete absence of particulate matter in the colon was especially remarkable. The mucosa was intact throughout, with only a moderate erythema, especially in the small intestine. The urinary tract was normal. No urine was present. The genital tract was normal; the cervix showed no signs of instrumentation. The uterus was gravid, measuring 18 cm. in length, with an intact amnion and sterile fluid in both aerobic and anaerobic media. The fetus weighed 200 Gm., measured 21 cm., crown-heel, and was normal. The pituitary gland showed anterior lobe hyperplasia and weighed 1.2 Gm. The thyroid, parathyroid, adrenals, pancreas, and ovaries were unremarkable except for a large hemorrhagic corpus luteum in the right ovary. The skull and vertebral column were intact. The brain, meninges, arteries, and venous sinuses were normal.

Extensive microscopic examination confirmed the gross impressions. There was focal pulmonary atelectasis and edema, a moderate degree of congestion in the liver and spleen, lymphoid hyperplasia of the thymus, and the usual gravid changes commensurate with a five-month gestation. Sections of the heart, central and peripheral nervous systems, voluntary muscles, lymph nodes, vessels, bones and marrow were normal, as were sections of the fetus.

Case 2

A 33 year old Negro woman, para 5-0-5, gravida 6, was admitted to another hospital at 9:45 P.M., October 10, 1958, with nausea, vomiting, diarrhea, and abdominal pain of 24 hours' duration. Her blood pressure was 70 systolic, 0 diastolic, and she was thought to be in labor. Treatment consisted of bed rest, olive oil given by mouth, demulcents, antibiotics, and intravenous fluids. This therapy was continued for 24 hours with no changes in blood pressure. Diarrhea persisted. Because of failure to respond to therapy, she was referred to Duke Hospital, arriving at 10:00 P.M. October 11.

The patient had had five illegitimate children, and had an intelligence quotient of 41 (Stanford-Binet). On April 9, 1958, she had had a bilateral partial salpingectomy, authorized by the North Carolina Eugenics Board. At that time she was confused.

On admission to Duke Hospital the temperature was 36.8 C., pulse 90, respiration 48, and blood pressure 80 systolic, 0 diastolic. The patient was semi-stuporous, but was able to move all extremities. The abdomen contained a gravid uterus. Fetal heart sounds were not heard, and the cervix was closed. There was no edema of the extremities. There was generalized hyporeflexia and hyperactivity to stimuli.

Admission laboratory data: The hemoglobin was 8.5 Gm., hematocrit 29, white blood cell count 17,400 with 69 polymorphonuclear neutrophils, 2 stab cells, 23 lymphocytes, and 6 mononuclear cells. The sickle cell preparation was negative. Urine could not be obtained. The nonprotein nitrogen was 46 mg. per 100 cc., the CO₂ combining power 18.3 mEq. per liter, sodium 133 mEq. per liter, chloride 92.6 mEq. per liter, potassium 2.5 mEq. per liter, serum acetone negative. The lungs were clear by x-ray. A flat plate of the abdomen demonstrated a near-term fetus. The electrocardiogram showed low T waves and sinus tachycardia.

Course in hospital: There was no diarrhea or vomiting during hospitalization at Duke. The continuous use of pressor amines was necessary to maintain the blood pressure at 70-80 mm. systolic. Approximately 16 hours following admission she delivered a 2,250 Gm. male infant spontaneously. The infant was in poor condition and expired after 12 hours. Autopsy findings were not remarkable. There was no abnormal bleeding. During the entire hospital course, the total intake was 8,450 cc., including 1,000 cc. of whole blood. The total output was 4,690 cc. The serum potassium never became greater than 2.6 mEq. per liter (with several determinations) in spite of administration of a total of 12 Gm. of KC1 in the intravenous fluids. Lumbar puncture findings were normal. Repeated urine, blood, and stool cultures were negative for pathogens. It became impossible to maintain the blood pressure and the patient expired October 15, five days after the onset of diarrhea.

Autopsy findings: Most of the findings at autopsy were related to shock. There was massive pituitary necrosis, selective neuronal necrosis (medulla predominantly), cloudy swelling of the liver and kidney, and mild fatty degeneration of the myocardium and renal tubules. Incidental findings included focal ulceration of the esophagus, focal pulmonary atelectasis, mild cardiac hypertrophy, multiple small tumorlets of the lungs, five intact medial defect aneurysms of the circle of Willis, surgical interruption of the Fallopian tubes and absence of the appendix, and bone marrow findings compatible with iron deficiency anemia. The intestinal tract contained very little fecal material, and there

was congestion of the intestines and gallbladder. There was neither bacteriologic nor histologic evidence of uterine infection.

Comment

The outstanding features that these 2 cases share are (1) unwanted pregnancy and (2) acute fatal illness of short duration characterized by severe diarrhea. We were told by law enforcement officers that the first patient came to this city to have an abortion performed, whereas tubal ligation was performed on the second after she had become pregnant. We may speculate that in both cases vascular collapse resulted from acute hypovolemia, as was certainly so in the second case. We can only surmise whether or not the pituitary necrosis was responsible for the continuation of shock in the second case. Certainly patients with similar cases have recovered, subsequently exhibiting hypopituitarism(14).

A colleague in obstetrics stated that he had recently seen a number of patients who presented nausea, vomiting, severe diarrhea, and prostration. Several of these had admitted ingesting bitter apple because of its reputed efficacy as an abortifacient. From communications which he has had, and which we have had from other sources. there is some reason to believe that the use of bitter apple as an abortifacient may be comparatively widespread among parts of the Negro population throughout the southeast. We have determined that it can be purchased without a prescription, in any desired quantity, in the form of a crude pulp or as an extract in various cathartic preparations. A poll conducted by a social worker in this hospital revealed that approximately half of the adult Negroes interviewed were familiar with colocynth. Many admitted to having taken the drug in small quantities as a tonic or laxative; however, considerable evasion was encountered when it was suggested that bitter apple was also in use as an abortifacient.

In any medicolegal problem in which a toxic agent is involved, methods for its detection are indispensable. In our hands, however, the various color reactions described in treatises dealing with toxicology have not been satisfactory in identifying the crude pulp of colocynth nor its different extracts in amounts which would be fatal in man. Fröhde's reagent, for example, is commonly cited as a reliable means of de-

tecting the alkaloidal fraction of colocynth(5a,15). In our laboratory however, this reagent has not proved useful even in detecting alkaloids in the direct extract of the pulp. In addition, there are many other substances which give a false positive reaction. Personal communication from the laboratories of Eli Lilly and other independent workers in the field convince us that others have had this same difficulty. By considering the various constituents of the fruit and the extremely large amount of material which was necessary for Power (13) to isolate small quantities of each constituent, the inherent difficulties in identifying any one of them can readily be appreciated. In our second case, because of the five day period between the onset of illness and death, any attempt to identify colocynth would not have been feasible. In the attempt to eliminate other poisons, a determination for heavy metals was performed and was negative. In the first case the small amount of gastrointestinal contents made it almost a foregone conclusion that chemical demonstration of its presence would not be possible. Successful isolation from tissues is not recorded. Even so, we have performed these examinations without suc-

In the first case the major portion of the gastric and upper intestinal contents was submitted for toxicologic examination. which was negative for alkaloids. The remainder was washed with water in search of particulate matter. Few gross fragments were found. A fragment of undigested meat and one kidney bean were found, and several small fragments of white pulp-like material were separated. The latter grossly appeared identical with crude colocynth. Botanical examination showed that it was microscopically identical with colocynth. The quantity ingested, however, is uncertain.

Many problems are inherent in the interpretation of these cases. It is well known that the presence of an agent in the gastrointestinal tract does not prove that death is due to this agent. We have been unable to demonstrate chemically the presence of colocynth in the autopsy specimens. This is of no significance for two reasons. First and most important, the fruit does not give the chemical reactions suggested in the literature. Second, in one of the cases the time interval was too long. The only reason for

presenting these 2 cases along with the material concerning bitter apple is circumstantial. Each patient was pregnant and wished to be aborted. Bitter apple is used as a cathartic and an abortifacient. After analyzing the material presented above, we feel that the only possible way to establish the diagnosis of colocynth poisoning is by history. If this be so, there may well be many undiagnosed cases of such poisoning. Better chemical tests are certainly necessary.

In an effort to study the physiologic and anatomic effects of bitter apple, a dog and several guinea pigs received the crude pulp.

A 36 pound female dog which received up to 5 Gm. of the pulp incurred severe diarrhea and became markedly weak. The dose was not fatal, however. The animal was sacrificed. An autopsy failed to disclose any anatomic lesion except mild congestion of the gastrointestinal tract, which was nearly devoid of contents. Six guinea pigs, weighing approximately 1,100 Gm. each, received an aqueous suspension of the crude pulp via stomach tube. Each animal was given 1 Gm.; however, varying amounts were regurgitated. Diarrhea was observed in all animals. Five of these animals died between 18 and 102 hours following administration of the drug. The sixth animal was sacrificed 140 hours after the feeding of colocynth. As in the dog, the only significant findings in these animals at autopsy was evidence of diarrhea.

Summary

The literature concerning colocynth has been reviewed. It has been shown that the present chemical tests recommended for the demonstration of the drug are unreliable. The difficulties in unequivocally establishing colocynth intoxication are discussed in the light of 2 cases presented.

References

- Pammel, L. H.: A Manual of Poisonous Plants, Cedar Rapids, The Torch Press, 1911, pp. 70, 749.
 Ebbell, B.: The Papyrus Ebers, London, Humphrey Mil-
- ford, 1937, p. 31.
- 3. (a) Gerharde, J.; The Herball or General Histories of Plantes, London, John Horton, 1597, p. 768, (b) Larkin, E., and Larkin, J.: Pharmacopoeia of the Massachusetts Medical Society, Boston, 1808, p. 13. (c) Beckman, H.:

Note: Since writing this paper we have found other color tests which are said to be useful in identifying colocynthin (Bamford, F.: Poisons, Philadelphia, Blakiston, 1947, p. 259.) Unfortunately, we have not had the opportunity to pursue these leads. Paper chromatography is also being investigated (Faust, R., and others: The Antineoplastic Action of Chemical Fractions of Citrullus colocynthis on Sarcoma 37, J. Am. Pharm. A. 47:1-5, 1958).

Pharmacology in Clinical Practice, Philadelphia, W. B. Saunders and Company, 1952, p. 369. (d) Bartholow, R.: A Practical Treatise on Materia Medica and Therapeutics, ed. 11. New York, Appleton and Company, 1903, p. 761.

4. Tidy, C. M.: On Poisoning by Cucumis Colocynthis, Lan-

cet, 1:158, 1868.

 Roe, R. B.: A Case of Colocynth Poisoning, Lancet, 1:1527, 1913.

Von Oettinger, W. F.: Poisoning, ed. 2, Philadelphia.
 W. B. Saunders and Company, 1958.

 Rolfe, W. A.: A Case of Colocynth Poisoning, Boston. M. & S. J. 126:494, 1892.

 (a) Peterson, F., Haines, W., and Webster, R.: Legal Medicine and Toxicology, ed. 2, Philadelphia, W. B. Saunders Co., 1923, vol. 2, p. 756. (b) Gonzales, T. A., and others: Legal Medicine, ed. 2, New York, Appleton-Century-Crofts, 1954, p. 837. (c) Claister, J.: Medical Jurisprudence and Toxicology, Baltimore, Williams and Wilkins, 1957, p. 646.

- 9. Walz: N. Jahrb. Pharm., 9:16, 225, 1858; 16:10, 1861.
- The Merck Index, ed. 6, Rahway, New Jersey, Merck & Co., Inc. 1952, p. 266.
- 11. Henke: Arch. Pharm. 221: 200, 1883.
- (a) Naylor, W. A. H., and Chappel, E. J.: On Cucumis Trigonus (Roxb.) and Colocynthin; The Pharmaceutical J. 79:117, 1907.
 (b) Johannson: Zeitsch. anal. chem. 24:154, 1886.
- Power, F. B., and Moore, C. W.: The Constituents of Colocynth, J. Chem. Soc. T. 97 (1), 99, 1910.
- Sheehan, H. L., and Summers, V. K.: The Syndrome of Hypopituitarism, Quart. J. Med., 18:319-378 (Oct.) 1949.
- (a) McNally, W. D.: Toxicology, Chicago, Industrial Med., 1937, p. 856. (b) Blyth, A. W.: Poisons: Their Pffects and Detection, London, Charles Griffin and Co., 1895, p. 244. (c) Brecht, E. A.: Personal communication.

The Doctor and the Deaf Child

BEN E. HOFFMEYER, M.A.

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The handicap of deafness is not one that strikes often. There is approximately one deaf child of school age to 8,000 population. We have 465 white deaf children in a state of approximately three and one-half million white people. By deaf children, I mean those children who have a hearing loss severe enough to prevent their progress in a public school. There are many more hard of hearing children who can attend regular school classes, with or without a hearing aid.

Realizing the Seriousness of the Handicap Deafness is a tremendous educational and social handicap that unfortunately has been greatly underestimated in the past.

Dr. Helmer R. Myklebust of Northwestern University has the following to say about the nature of deafness and its effect

on the total organism(1):

Hearing and vision are the distance senses. Normally, these senses continuously supplement each other. However, vision is usually directed specifically to the task at hand (foreground) while hearing serves to keep the individual in contact with the total environment (background). This is based on the natural, inherent aspects of hearing and vision. For example, vision is directional—we see only in front of us—while hearing is nondirectional, covering and keeping in touch with the total environment simultaneously and continuously...thus, vision, as much as possible, must be used for both foreground and background purposes. In addition, the kinesthetic sense becomes the

sense of awareness and warning. Vibrations are felt, then the sense of seeing is directed to explore the situation further: Instead of hearing and vision, the supplementing senses now become kinesthesis and vision. However, kinesthesis is a much less effective sense than hearing for contact and exploratory purposes. There are always discrepancies between what an individual thinks the environment is like and what it is really like. But when the individual is deaf this discrepancy is likely to be greater ... It is becoming apparent, and the new understanding of the deaf child must emphasize, that it is very difficult to know what the real world is like when you do not hear; it is easier when you are deaf to accept distortions on the basis of misconception. Deafness causes the individual to behave differently... It causes the individual to see differently, to smell differently, to use actual and kinesthetic sensation differently, And perhaps more important than all of these, but because of them, the deaf person perceives differently. As a result of all these shifts in functioning, his personality adjustment and behavior are also different. To say that the deaf person is like the hearing person, except that he cannot hear is to oversimplify, and to do an injustice to the deaf child. His deafness is not only in the ears, it pervades his entire being... To see this is not to be pessimistic, it is not to be hopeless. It is to see deafness for the severe organismic deprivation which it is. The program then is broad, not narrow. It varies according to the individual needs of children; it considers basic differences such as age of onset, etiology, degree of deafness, and personality differences."(1)

So when we think of deafness, we generally do not fully realize what hearing does for us. Helen Keller once said in an inter-

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view with a New York *Times* reporter: "Deafness is even more isolating than blindness."

Helping Parents Face Reality

I beg of you doctors to help parents to face reality if their children have incurable deafness. There are parents who compound the problem by clinging to the hope that hearing can be restored by medical or magical means. They plead for fenestration, spinal adjustments, faith healers, hearing aids purchased without discrimination-even airplane rides. Slightly more realistic parents may accept their child's handicap, but expect the use of a hearing aid to endow him with perfect hearing, normal speech and language, and no observable handicap. The truth is, that in most cases of severe deafness, there will always be a handicap. The well adjusted parent aims to help the child become a competent, happy, well adjusted person with a hearing impairment, rather than a pale, poor imitation of a hearing person always laboring to conceal his handicap.

I fully realize that a parent will often go from doctor to specialist, to clinic and back again, hoping to get the answer he wants to hear. So often these parents are sure the child hears because he responds to the passing of a truck or an airplane, the slamming of a door, or a loud shout. These he may do, but still be unable to acquire speech and language through hearing. Sound perception and the discrimination of speech sounds are two different things. It has been said that there is no such thing as a totally deaf person. That is true, for sound, highly amplified, becomes feeling, and a person will respond to it. But is it hearing? Certainly not, as far as everyday living is concerned.

Making the Diagnosis

Early diagnosis is crucial, and is not always easy. The audiometer is far from adequate for a child under 6 years of age.

Dr. John E. Bordley of Baltimore says: "In any discussion of the establishment of hearing status in preschool children, certain facts have to be remembered. When the clinician attempts to measure hearing efficiency in a child under 2 years of age, he...is dealing with a patient who, under normal circumstances, has very little ability to communicate and whose speech, at best, must be limited to a vocabulary of a few words.

Several very helpful techniques for evaluation of hearing in infants or in children of the preverbal group have evolved through the years. The Ewings in England have worked with infants in a very successful method of screening infants in well-baby clinics by the use of what could be termed environmental audiometry.

The psychogalvanic skin resistance test (PGSR) has been very successfully carried out in children as early as one week after birth. At this period, little attempt has been made to establish a threshold for hearing. The object has been merely to establish sound perception.

In the preverbal group, calibrated toys and noise makers can be used successfully.

As the child approaches school age, pure tone audiometry can be begun and speech hearing testing with simple word lists becomes accurate and easy. Discrimination tests can be made when warranted at this point." (2)

I also quote from Dr. Hollie E. McHugh:

"There are four major groups of children who, because of their failure to develop normal speech at the appropriate time, are suspected of having impaired hearing, namely, the deaf or hard of hearing, the brain injured (including those with aphasia), the mentally retarded, and the autistic or emotionally disturbed.

Approximately 50 per cent of the children who have failed to acquire speech by the age of two and a half years are reported to have a significant peripheral hearing loss; the remaining 50 per cent have some central dysfunction as the basic cause of their handicap."(3)

Indications for Special Aids and Educational Procedures

The age of onset and the degree of hearing loss govern the educational procedures. In general, a critical point is reached when the loss is at 30 decibels. Communication difficulties begin at this level, unless a hearing aid is used.

Another critical point is when the loss is perhaps a little more than 60 decibels, for then even with a hearing aid, lipreading must be used to supplement hearing.

If a child becomes deaf before three years of age and has a loss of 60 or more decibels, he will not develop speech and language sufficient for normal communication. He will need special educational measures.

In other words, if a child has a loss of 60 or more decibels, he will need extensive help, probably in a special school. The need varies with the degree of intelligence and emotional adjustment and the help he receives at home or from his local school.

North Carolina is quite fortunate now in having four centers which have PGSR testing-namely, North Carolina Baptist Hospital, Winston-Salem, Dr. Malcolm B. Mc-Coy, audiologist; Duke University Hospital, Durham, Dr. Ralph A. Arnold and Dr. Roderick B. Ormandy, audiologists; North Carolina Memorial Hospital of the University of North Carolina, Chapel Hill, Dr. Newton D. Fischer, audiologist; and Charlotte Rehabilitation and Spastic Center, Mr. W. E. Rankin, audiologist.

We have found referrals from these centers very reliable. They assure us of the type and degree of hearing loss, and the type of hearing aid to use, if any; and this valuable information enables us to determine whether or not the child is a candidate for our school. We do not require all prospective students to have a PGSR, but

certainly strongly urge it.

Dr. S. Richard Silverman of St. Louis says:

"If we are guided by the dimension of hearing loss, educational guidance for children with impaired hearing should recognize:

Group 1: Less than 30 decibels. The child may having difficulty in hearing faint to distant speech; he is likely to 'get along' in school, and he has normal speech.

Group 2: 30 to 45 decibels. Conversational speech is understood at a distance of 3 to 5 feet without too much difficulty. The child may have some articulatory defects, and he may have difficulty in school if the speaker's voice is faint or if his

face is not visible. Group 3: 45 to 60 decibels. Conversation needs to be loud to be understood, and the child has difficulty in group and classroom discussion. Language, especially vocabulary, may be limited and deviations of articulation and voice are noted. Group 4: 60 to 80 decibels. The child may be able to hear voices about one foot from the ear. He may identify environmental noises and may distinguish vowels, but he will have difficulty with consonants. His voice may show signs of deviation. Speech and language need to be taught. Group 5: 80 plus decibels. The child may hear some loud sounds. Speech and language need to be developed through training."

The Special Education Program in North Carolina is having a difficult struggle to get enough teachers to provide the hard of hearing child with the speech and language training he needs. Too often the attitude is taken that the hard of hearing child only needs speech correction; this is not true. His basic lack is language development, which retards him in all phases of his education. A half-hour of help per day is not sufficient, and most special education teachers are so overloaded that they cannot spare more time than this.

Hearing aids

When is a hearing aid indicated? The audiogram is the guide for a child of school age. The child with a hearing loss of 30 decibels in the better ear should be fitted with a hearing aid. He should be made to realize, however, that no mechanical aid will insure perfect hearing, despite the optimistic claims of some manufacturers.

Great harm is often done in requiring children to wear hearing aids for long periods of time in the initial stages. Often a child is turned against a hearing aid because he was forced to wear it for long periods before he became accustomed to it. A hearing aid is not a comfortable instrument to wear, and time and guidance are necessary to make a child a faithful user.

Nearly all deaf children can profit some from auditory training. Those who are profoundly deaf can get only accent and rhythm through a hearing aid; they do not get speech patterns. Experience has shown that lipreading is materially enhanced by the use of a hearing aid in most cases. I would like to emphasize, however, that each deaf child is an individual, and that a hearing loss does not automatically make all deaf children alike. The educative processes cannot be determined purely by an audiogram.

Lipreading

Lipreading, sometimes called speechreading, is a skill, and the ability to master it varies from person to person. The eye and the ear together appear to be better than either functioning alone. Lipreading is a very useful skill, especially when only two persons are involved. A skilled lipreader, however, finds it quite inadequate in a group. Since he has no way of knowing who is about to speak, he soon becomes lost in a group conversation.

Speech for the deaf

Developing speech in the deaf child is one of the most difficult educative processes. Only a trained teacher endowed with patience and skill can develop speech in a child who has never heard it nor ever will hear it. There are 46 speech elements in the English language. The position and sound of each of these elements must be mastered by the deaf child through vision and feeling.

Speech and lipreading can be developed to a very useful degree in approximately 75 per cent of the students who come to a state school for the deaf. This percentage can be increased only if the school is private and can select its student body. In a state school for the deaf, where all educible deaf children are accepted, at least 25 per cent will never acquire speech and lipreading to a degree adequate for conversation. This group will have to resort to pad and pencil or manual means of communication. Any organization or educational institution that promises more, unless its students are selected, is guilty of misrepresentation.

Procedures of the North Carolina School for the Deaf

Parents of prospective deaf students are required to bring the deaf child to the North Carolina school for the deaf prior to enrollment. We very much like to establish contact with these parents at the earliest age possible after the diagnosis of deafness is made. We can guide them in their adjustment to having a deaf child in the family and assure them that the child will receive adequate care and professional teaching at the North Carolina School for the Deaf.

The North Carolina School for the Deaf at Morganton, admits pupils at 5 years of age. All pupils are given an opportunity to learn speech and lipreading. After approximately five years of concentrated work in these areas, we are generally able to decide which students will be able to continue oral instruction and which will have to resort to other means of education. Those who cannot learn orally must be given special education within special education, which means we must use any effective methods to further their education that can be devised.

The first two years of school are ungraded, for the deaf child is void of vocabulary, and before grade work can begin there must be two years of concentrated language and speech development. The normal deaf child, therefore, requires 14

years to complete high school. The more intelligent deaf student has an opportunity to go to college. There is one college for the deaf in the world: Gallaudet College of Washington, D.C. While few very outstanding deaf students can attend regular college, this achievement is considered quite unusual.

The North Carolina School for the Deaf offers extensive vocational courses for boys and girls. The boys have an opportunity to learn printing (linotype), dry cleaning and pressing, machine shop and welding, and wood-working, including cabinet making. The girls have an opportunity to learn typing, key-punch operation, rower sewing machine operation, and hosiery looping. A complete home economics course is required of all girl graduates.

The North Carolina School for the Deaf is entirely state supported, except for a \$25.00 yearly fee for school and dormitory supplies.

Conclusion

Again I urge physicians to be realistic in dealing with the parents of a deaf child. If he has a hearing loss of more than 70 decibels, do not lead the parents to think that one or two years at the North Carolina School for the Deaf will solve his educational problem, and that after that he can return to public school. Some children are returned to public school. It is much wiser, however to state honestly that only time will tell whether or not this is possible.

Deafness is not a minor handicap, and it behooves all of us to face the fact, for if we, the normal, cannot be realistic about the handicap of deafness, how can we expect the deaf to adjust to it?

References

- Mycklebust, H.R.: Towards a New Understanding of the Deaf Child, presented at the Convention of American Instructors of the Deaf, 1955.
- Bordley, J. E.: Evaluation of Hearing in Pre-School Children, Tr. Am. Acad. Ophth. & Otoloryng. 61:706-707 (Nov.-Dec.) 1957.
- McHugh, H. E.: Problems of Testing and Managing Children with Communication Difficulties, Tr. Am. Acad. Ophth. & Otolaryng. 61:708-710 (Nov.-Dec.) 1957.
- Silverman, S. R.: Nonmedical Care of Children with Hearing Impairment, Tr. Am. Acad. Ophth. & Otolaryng. 61:723-726 (Nov.-Dec.) 1957.

SPECIAL REPORT

REPORT OF ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION THIRTEENTH CLINICAL MEETING DECEMBER 1-4, 1959 DALLAS, TEXAS

Freedom of choice of physician, relations between physicians and hospitals, a scholar-ship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4 in Dallas

Dr. Chesley M. Martin of Elgin, Oklahoma, was named as the 1959 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Martin, who has practiced in Elgin for the past 44 years, was the thirteenth recipient of the annual award and the first Oklahoman to be so honored.

Speaking at the Tuesday opening session of the House, Dr. Louis M. Orr of Orlando, Florida, A.M.A. President, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs, and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tnesday morning session. Senator Lyndon B. Johnson, majority leader in the U. S. Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U. S. House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

Total registration through Thursday,

Prepared by Dr. F. J. L. Blasingame of the A.M.A. and submitted for publication by Dr. Elias S. Faison, Secretary of the North Carolina delegation to the A.MA. with half a day of the meeting still remaining, had reached 4,727, including 2,742 physicians.

Freedom of Choice

In considering four resolutions which in various ways would have changed or replaced the statements on freedom of choice of physician which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

Physician-Hospital Relations

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superceded."

The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides summarize the following general principles as a basis for adjusting controversies:

"1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

- 1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.
- 2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.
- 3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two year or a full four year basis.
- 4. Investigate the securing of competent medical faculties. \cdot
- 5. Investigate financing of expansion and establishment of medical schools.

- 6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.
- 7. Develop methods of getting well-qualified students to undertake the study of medicine.
- 8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June, 1960.

Relative Value Studies

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nation-wide study or a series of regional studies by the A.M.A. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered, and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. It commended the Committee on Medical Practices, however, for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

Miscellaneous Actions

In considering 44 resolutions and a large volume of annual, supplementary, and special reports, the House also:

Learned that the A.M.A. Board of Trustees has appointed a liaison committee to meet with a similar committee of the

American Osteopathic Association to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of pharmacies or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new guide on the cardiovascular system in the A.M.A. *Journal*;

Recommended that Association councils and committees, whenever feasible, hold their meetings in the remodeled Chicago headquarters;

Called for investigation of the need, desirability and feasibility of establishing a home for aged and retired physicians;

Commended Dr. F. S. Crockett, retiring chairman of the Council on Rural Health, for his many years of devoted duty;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in Nursing Homes and Related Facilities":

Suggested that fees for consultative examinations under programs of the Bureau of Old Age and Survivors Insurance should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the Veterans Administration, urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of Blue Shield concept and directed the Council on Medical Service to submit at the June, 1960, meeting its recommendations concerning a policy statement on A.M.A. relationship with Blue Shield plans;

Suggested that S. J. Res. 41, a bill which would institute a separate program of international medical research, be delayed until an over-all assessment can be made of proposals now before Congress dealing with domestic and international medical research:

Endorsed the program of the Educational Council for Foreign Medical Graduates but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that medical schools include in

their curricula a course on the social, political, and economic aspects of medicine;

Declared that the threat of nuclear warfare has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the A.M.A. make available to school libraries information and literature showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of aircraft crew members should be made by doctors of medicine with special knowledge and proficiency in certain techniques;

Urged the American people to get proper tetanus toxoid, original and booster, and other immunizations as indicated from their physicians, and called on A.M.A. members to cooperate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all fluoroscopes and radiographic equipment;

Approved the Speaker's proposal that the opening session of the House, at the Interim Meeting, be moved from Tuesday morning to Monday morning, with the reference committees meeting on Tuesday and the House reconvening on Wednesday afternoon:

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the Forand type of legislation;

Urged state and local medical societies and individual physicians to implement the A.M.A. program for recruitment of high-grade medical students:

Changed the title of the Section on Surgery, General and Abdominal, to the Section on General Surgery;

Accepted with appreciation a \$2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring the name of Dr. Thomas G. Hull, retiring secretary of the Council on Scientific Assembly, and

Reaffirmed the "Suggested Guides to Relations Between Medical Societies and Voluntary Health Agencies," which were adopted at the December, 1957, meeting in Philadelphia.

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January, 1960

1960

Although the first decade of the twentieth century will not end until the last day of the year, 1960 is generally hailed as the beginning of another decade. It is doubtful if any similar period of time since the birth of Christ has been more eventful than has this century—with the possible exception of the era after the discovery of America

This century has already experienced two World Wars; a major world-wide depression; the beginning of the Welfare State; unprecedented material prosperity; and the emergence of the United State and Russia as the two most powerful nations on earth, each with widely differing ideologies.

Scientific tests have succeeded in unleashing the terrific energy of the atom, with its power for good or evil. Fantastic speed in the air is now commonplace. The conquest of space is the next objective.

Medicine has made spectacular gains. Infectious diseases that have been scourges of man for centuries have been virtually eliminated; giant strides have been made in surgery; arthritis is better understood; and

the average life span has increased from about 40 years in 1900 to the Biblical three score and ten.

In North Carolina our State University School of Medicine was expanded to a four-year school. Our state now has three approved four-year medical schools, graduating about 200 young doctors every year. These schools with their teaching hospitals are three medical centers which attract thousands of patients every year. No longer need a patient leave the state to get the latest methods of diagnosis and treatment.

These achievements have brought problems. Our prosperity has been achieved to a great extent by mortgaging future individual, municipal, state and federal incomes. The steel strike settlement may initiate another round of inflation, with further devaluation of the dollar and increase in the cost of living.

The mastery gained over disease and the resultant increased life span, with a birth rate virtually stationary, threatens the world with an explosive increase in population, which may precipitate more struggles for living room. One shudders to think of the consequences of a great war in which the fearful instruments of destruction now available might be used. Man has created what could be a veritable Frankenstein monster. If the human race is not capable of controlling its own inventions, does it deserve to survive?

Let us hope and pray that answers to our many problems may be found before the century ends—and that man's inventive genius will turn to making instruments for peace rather than for war.

The last two stanzas of Kipling's masterpiece, the Recessional, were quoted in this Journal nine years ago, but are so appropriate for our time that they are repeated here:

If, drunk with power, we loose Wild tongues that have not Thee in awe—Such boasting as the Gentiles use Or lesser breeds without the Law—Lord God of Hosts, be with us yet, Lest we forget, lest we forget!

For heathen heart that puts her trust In reeking tube and iron shard—All valiant dust that builds on dust—And guarding calls not Thee to guard—For frantic boast and foolish word, Thy mercy on Thy people, Lord!

EDITORIALS 35

DR. W. S. RANKIN

A most appropriate birthday celebration was the dedication on January 18 of the W. S. Rankin Health Center, "built by the citizens of Charlotte and Mecklenburg County," and "dedicated to the promotion, protection and preservation of the health of all the people."

It is hard for his friends who know his energy and forward-looking nature to realize that this day marked the eightv-first anniversary of his birth—but the record shows that he was born in Cabarrus County, January 18, 1879. Few North Carolina doctors have had as distinguished a career as he, or have rendered greater service to mankind.

His first public service was teaching in the infant Wake Forest two-year medical school. As its dean he was largely responsible for its gaining recognition as an excellent training ground in the basic sciences.

In 1909 he became North Carolina's first whole-time State Health Officer, and within the next 16 years made our State Health Department a model for other states.

In 1925 he became director of the Hospital and Orphan Section and a trustee of the Duke Endowment. He retired as director, but is still a consultant to the Hospital and Orphan Section.

Among his many honors Dr. Rankin has been president of the American Public Health Association; trustee of the American Hospital Association; the first chairman of the Charlotte Board of Health; a member of the North Carolina Medical Care Commission; and a trustee of Wake Forest College. He has been given honorary Doctor of Science degrees by Duke University, the University of North Carolina, Davidson College, and Wake Forest College.

For once, the editor of the NORTH CAR-OLINA MEDICAL JOURNAL is inserting a personal note. It was his privilege to have Dr. Rankin for his first medical teacher. The high professional standards taught and practiced by the young teacher have been an inspiration for more than half a century. At the risk of being sentimental, the editor wants to acknowledge here a debt of gratitude to his former teacher, and to say that Dr. Watson Rankin has served as an ideal whose example he has tried to follow in his own practice and teaching.

THE MISSISSIPPI DOCTOR

The December issue of the *Mississippi Doctor* marks the end of its publication as the last private-owned state medical journal, after 37 years and 7 months. During most of its existence it has been edited by Dr. W. H. Anderson, with the able help of his wife, Mrs. Mildred P. Anderson.

Dr. Anderson has generously given the journal to the Mississippi State Medical Association. Beginning January, 1960, it will be the Association's official organ, and will join the State Medical Journal Advertiser's

Bureau group of state journals.

In the November issue of the Mississippi Doctor, Dr. Fount Richardson, president of the American Academy of General Practice, has a salute to Dr. Anderson. This JOURNAL quotes with approval Dr. Richardson's concluding words:

"As publication of the *Mississippi Doctor* is taken over by a state-managed organ, its editor can look back on many years of ac-

complishments . . .

"Like many a physician, Dr. Anderson's retirement from the publication of his journal does not mean that he is retiring from medicine... He will be doing his part in medical care, unless he becomes incapacitated, for years to come. He has served organized medicine, his community, his state, and his patients. What doctor has done more? Few have done as well."

A CONTROLLED STUDY

A justifiable criticism of many, if not most, recent papers evaluating new drugs is that their effects are not compared with a control group, and too often conclusions are based on the patients' subjective responses. It is easy for an investigator to let his own enthusiasm influence his patients' responses. Many glowing reports on the merit of some new drug have had to be retracted or modified later.

The paper in this issue by Drs. Ira and Bogdonoff is a model study of a new oral diuretic drug, benzydroflumethiazide (Naturetin). It was given for the same periods of time as the well known chlorothiazide

(Diuretin). For the same period no diuretic was given. No clinical comments were offered, and the weight loss was the sole criterion of results. This was slightly less with the new drug than with chlorothiazide, but the difference was considered insignificant.

Congratulations are due Drs. Ira and Bogdonoff for their excellent study. May other studies be as well controlled as theirs.

ORCHIDS FOR DUKE HOSPITAL

A reporter for *Medical Economics* (December 21) asked a number of doctors who have had occasion to observe closely the teaching hospitals in the United States to name the ones which they thought offered the best training programs. They all agreed on a list of 13 hospitals that they considered at the top. The criteria used in the evaluation were:

- 1. Plenty of interesting clinical material with rapid turnover
- 2. Emphasis on using case material rather than lectures and academic work
- 3. Increasing responsibility for the care of patients by house officers
- 4. Only the essential amount of supervision by the chief of service
- 5. Adequate outpatient emergency and radiology departments; all clinical specialties well represented; and a good library and laboratory.

North Carolina can be proud that Duke was given second place. The only other Southern hospital included was Johns Hopkins, which was fifth on the list.

Seventeen other hospitals were placed on a second All-American team. The Southern hospitals in this list were Charity Hospital in New Orleans, Vanderbilt University Hospital in Nashville, Tennessee, and Walter Reed Hospital in Washington, D. C.

MASCULINITY AND SMOKING

Although a study reported in the December 18 issue of *Science*—the weekly magazine of the American Association for the Advancement of Science—was supported by the Tobacco Industry Research Committee, if it gains wide circulation it may do more than the fear of cancer to discourage men from smoking. The report concerns a study made of 252 Harvard students who were selected in 1938-1942 as apparently normal individuals.

Part of the study included their smoking habits and also their masculinity as determined by their morphologic features. Their masculine components were classified as strong, moderate, weak, and very weak. The study, as reported by Dr. Carl C. Seltzer, indicated that 96.7 per cent of the non-smokers, 90.4 per cent of the moderate smokers, and 82.8 of the heaviest smokers has a strong masculine component. Of the non-smokers, 3.27 per cent had a moderate masculine component, compared with 7.5 per cent of the moderate smokers and 8.6 per cent of the heaviest smokers.

None of the non-smokers were tagged as having a weak masculine component, but 2.1 per cent of the moderate and 7.5 per cent of the heaviest smokers were so labeled. The only one with a very weak one was a heavy smoker.

Dr. Seltzer commented that "These less masculine persons tend to have an aversion to strenuous exercise and sports, are apt to be low in physical fitness or hard muscular work, and are often poor in muscular coordination. In the sphere of personality structure, they appear to be more sensitive in affect and manifest a greater degree of instability of the autonomic nervous functions. They are apt to be less well integrated and more ideational, creative, and intuitive. They are more frequently shy and asocial and more frequently have traits of self-consciousness and inhibitions."

One may naturally wonder if the efforts now being made on TV commercials to identify the cigaret smoker as the outdoor, hunting, fishing, hard-riding he-man mean that some Madison Avenue agent has seen an advance copy of this report. At least the publication indicates that the Tobacco Industry Research Committee hews to the line, let the chips fall where they may.

BULLETIN BOARD

COMING MEETINGS

Watts Hospital Symposium—Durham, February 18.

Sixth Annual North Carolina Conference on Children with Special Needs: "The Gifted Child"—Duke University, Durham, February 25-26.

Greensboro Academy of Medicine, Annual Meeting—Greensboro, March 24.

Ninth Annual Cancer Symposium, sponsored by the Forsyth County Medical Society in cooperation with the Forsyth Cancer Service—Winston-Salem, March 31.

Eighth Annual North Carolina Hospital Food Service Institute—North Carolina State College, Raleigh, April 6-8.

Medical Society of the State of North Carolina

Annual Meeting-Raleigh, May 8-11.

American Academy of Occupational Medicine—Williamsburg, Virginia, February 10-12.

American Society of Psychosomatic Dentistry and Medicine, Annual Meeting—Shoreham Hotel, Washington, D.C., March 11-13.

American College of Chest Physicians, Thirteenth Annual Postgraduate Course in Diseases of the Chest—Sheraton Hotel, Philadelphia, March 14-18.

American Academy of General Practice, Twelfth Annual Scientific Assembly—Philadelphia, March 21-24.

American Association for the History of Medicine—Charleston, South Carolina, March 24-26.

Chicago Committee on Trauma of the American College of Surgeons, Fourth Postgraduate Course on Fractures and Other Trauma—Chicago, April 27-30.

Fourth National Cancer Conference under the sponsorship of the American Cancer Society, National Cancer Institute—Minneapolis, Minnesota, September 13-15. (Address inquiries to the American Cancer Society, Medical Affairs Department, 521 West 57th Street, New York 19.)

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of December, 1959:

Dr. Octavius Blanchard Bonner, Jr., 36 Oakwood Drive, Chapel Hill; Dr. Conway Hamilton Ficklen 306 North 11th Street, Wilmington.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

The University of North Carolina School of Medicine held a pediatric-cardiology symposium here January 13-15.

This symposium will be postgraduate work in heart disease in childhood with emphasis on relation of clinical findings to disturbances of the patient.

The speakers on the symposium will be faculty members of the Department of Pediatrics and Medicine of the UNC School of Medicine, Dr. Edward Lambert of the University of Buffalo and Dr. Robert F. Castle of the Duke University School of Medicine will be guest participants.

Additional information on this event may be had from the UNC School of Medicine, Chapel Hill.

The first University of North Carolina medical postgraduate courses of the new year will be held at Edenton, Rocky Mount and Roanoke Rapids.

The weekly lectures got under way in Edenton on Wednesday, January 13. The lectures will continue in Edenton for the next six weeks with the exception of the week of February 7.

Beginning Thursday, January 14, the lectures will alternate between Rocky Mount and Roanoke Rapids with the first being at Rocky Mount. No lectures will be held during the week of February 7 due to a conflict with the Watts Hospital Symposium in Durham.

The courses are sponsored by the UNC School of Medicine and the UNC Extension Division. The Edenton course is co-sponsored by the First District Medical Society. The Rocky Mount-Roanoke Rapids course is co-sponsored by the Edgecombe-Halifax-Nash Medical Societies.

The visiting lecturers for the two courses will be Dr. Fred R. McCrumb, University of Maryland School of Medicine; Dr. Laurence S. Fallis, Henry Ford Hospital, Detroit, Michigan; and Dr. Benjamin Manchester, George Washington University School of Medicine.

Faculty members of the UNC School of Medicine who will take part in the two courses include Drs. Arthur H. London, Luther M. Talbert, Jeffress G. Palmer, James F. Newsome and Paul L. Bunce.

Physicians desiring additional information on these courses may write the Office of Continuation Education, UNC School of Medicine, Chapel Hill.

Dr. Warner Wells of the Department of Surgery of the University of North Carolina School of Medicine delivered the Fall Humanities Lecture at the University of North Carolina on December 16. The title of his speech was "Our Technological Dilemma: An Appraisal of Man as a Species Bent Upon Self Destruction."

The work of Dr. John A. Ewing, associate professor of psychiatry, has received prominent attention in a national magazine.

The article, explaining Dr. Ewing's work in alcohilism, was carried in the December issue of Cosmopolitan magazine. It explains Dr. Ewing's work in group psychotherapy not only with the

alcoholic husband, but with the patient's wife. Dr. Ewing's co-workers is his three and a half year program at Chapel Hill have been Virginia Long and Gustave G. Wenzell.

The conclusions on this particular point of treatment showed that the husbands made greater improvements when the wives attended the concurrent meetings. The value of the meetings for wives was in the explanation of the disease of alcoholism as well as what wives could do to aid in the treatment of the disease.

Dr. Richard L. Dobson of the University of North Carolina School of Medicine delivered a paper at a meeting of the American Academy of Dermatology in Chicago recently. His presentation dealt with recent studies of the histochemistry of corrective tissue.

Dr. William P. Richardson, assistant dean for Continuation Education, has announced plans for a Physicians' Institute on Alcoholism to be held at the University of North Carolina School of Medicine on April 6. This will be a one-day program.

Participants in the program include: Dr. John A. Ewing, associate professor of psychiatry, University of North Carolina School of Medicine; Dr. Thomas T. Jones, Durham; Dr. Norbert L. Kelly, associate director, the North Carolina Alcoholic Rehabilitation Program; Dr. Donald E. McDonald. director (medical) of the North Carolina Alcoholic Rehabilitation Program; Dr. Charles T. Wilkinson, Wake Forest; and Dr. George C. Ham, professor and chairman of the Department of Psychiatry, University of North Carolina School of Medicine.

NEWS NOTES FROM THE DUKE UNIVERSITY SCHOOL OF MEDICINE

A new research training program in psychiatry is scheduled to be initiated at the Duke University Medical Center this year.

Purpose of the program is to provide more research scientists in the fields of mental health and disease.

Financial support scheduled to total \$165,000 over a five-year period has been allotted to Duke by the National Institutes of Health, principal research arm of the U. S. Public Health Service.

Trainees in the program will be persons with potentiality for research careers who hold the M.D. degree and who are engaged in or have completed their residency training in psychiatry.

Dr. Ewald W. Busse, chairman of the Medical Center's Department of Psychiatry, said that the two-year training period will include formal instruction, contacts with established investigators in psychiatry and other fields, participation in short-term and long-term research projects, and participation in conferences and seminars.

Ralph L. Drake has been appointed director of Duke Hospital's Outpatient Department, according to an announcement by Charles H. Frenzel, hospital superintendent.

Formerly an assistant director of the Outpatient Department, Drake succeeds L. R. Jordan, who resigned to become director of the Teaching Hospital and Clinics at the University of Florida.

Colonel Albert J. Glass, chief psychiatry and neurology consultant to the Office of the Surgeon General, Department of the Army, delivered a lecture at the Duke University Medical Center on January 12. He spoke on "Psychological Problems in Disaster Situations."

His appearance was sponsored by the Medical Education for National Defense (MEND) program,

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. James A. Harrill, professor of otolaryngology, has been elected president-elect of the Forsyth County Medical Society. He will succeed Dr. Charles R. Welfare, assistant professor of clinical internal medicine, in late 1960 or early 1961.

The trustees of the Z. Smith Reynolds Foundation have awarded a grant of \$150,000 to the Medical School to continue the program of scholarships. The plan provides for eight scholarships of six years each for students who plan to remain in North Carolina to practice medicine.

On January 1 the 60-room Graylyn main house, closed one year ago as the adult psychiatry unit of the Bowman Gray School of Medicine, was reopened as a multiphasic center for exceptional children. The function of the Center will be to deal with emotional neurologic problems confronting children. The entire program is under the direction of Mr. Joseph R. Grassi, assistant professor of psychology at Bowman Gray and director of the Medical School's Psychology, Reading and Speech Center at Reynolda.

Dr. Henry G. Cramblett, former assistant professor of pediatrics at the State University of Iowa, joined the faculty of Bowman Gray on January 1. His position here is that of associate professor of pediatrics, director of the virology laboratory and associate in microbiology and pathology. Dr. Cramblett's specialty is infectious diseases in children.

NORTH CAROLINA SURGICAL ASSOCIATION
The North Carolina Surgical Association held
its fall meeting at the Carolina Hotel, Pinehurst,

on October 11, 12, 13, 1959.

The program consisted of papers by Dr. E. R. Hipp on "Diagnosis and Treatment of Colonic Polyps"; by Dr. Donald Koontz on "Differential Diagnosis of Pelvic Pain in the Female"; by Dr. Alfred Hamilton on "Treatment of Pelvic Pain in the Female"; and a panel discussion by Dr. Josh Camblos, Dr. William Noel, Dr. Addison Brenizer, Dr. George Paschal, and Dr. Joe Patterson on "Surgical Treatment of the Peptic Ulcer."

Officers elected were Dr. Isaac E. Harris, Jr., Durham, president; Dr. Theodore S. Raiford, Asheville, president-elect; Dr. Richard Myers, Winston-Salem, vice-president; Dr. Alfred Hamilton, Raleigh, secretary-treasurer, Dr. Woodall Rose, Ral-

eigh, assistant secretary-treasurer.

NORTH CAROLINA ACADEMY OF GENERAL PRACTICE

Dr. Ralph B. Garrison of Hamlet was installed as president of the North Carolina Academy of General Practice at Jamaica on November 11 while on a Caribbean cruise sponsored by the Academy and the Bowman Gray School of Medicine of Wake Forest College. He was elected to the office during the annual meeting of the academy held in Greensboro in October.

NORTH CAROLINA HOSPITAL FOOD SERVICE INSTITUTE

The Eighth Annual North Carolina Hospital Food Service Institute is to be held at North Carolina State College, Raleigh, April 6, 7, 8. This Institute is planned for food service supervisors employed in hospitals having 20 or more beds. Particular emphasis will be placed on helping the supervisor who serves in an administrative capacity. Certificates will be given to those attending the entire Institute.

Miss Myrtle B. VanHorne, Project Director, Food Service Supervisor Program, American Dietetic Association, will participate on the program and will also serve as a consultant throughout the institute. Several of the program high lights include: a discussion on being a better supervisor; a demonstration on the use of nonfat dried milk in budget menus; group discussions on planning the diabetic diet; and a presentation on quality food versus food costs.

The registration fee is \$7.50 for persons working in North Carolina and \$10.00 for out-of-state registrants. North Carolina hospitals will receive announcements. Food Service Supervisors working in other states who would like to attend are asked to write to the North Carolina Hospital Food Service Institute. State Board of Health, Raleigh, North Carolina.

This institute is co-sponsored by the North Carolina Hospital Association, the North Carolina Dietetic Association, and the North Carolina State Board of Health.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled examinations (Part II), oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from May 11 through 16, 1960. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part 1 Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

The deadline date for the receipt of new and reopened applications for the 1961 examinations is August the first, 1960. Candidates are urged to submit their applications as soon as possible before that time.

AMERICAN MEDICAL WRITERS ASSOCIATION

The January issue of the Mississippi Valley Medical Journal is the annual American Medical Writers' Association issue of that publication and contains the presentations given at the Annual Meeting of the Association and its Conference on Medical Writing held at St. Louis last October 2-3. There are numerous presentations (25) on various phases of medical communications including the technical aspects of medical writing, publishing and editing, and the contributions of other arts and sciences to medical writing.

AMERICAN COLLEGE OF SURGEONS

Dr. John Paul North, Dallas, Texas, has become the director of the American College of Surgeons, An analysis of the 1959 poliomyelitis experience by Dr. I. S. Ravdin, Chairman, Board of Regents, American College of Surgeons. He will succeed Dr. Paul A. Hawley, the College's Director since

March, 1950.

AMERICAN COLLEGE OF CHEST PHYSICIANS
The thirteenth annual postgraduate course in
diseases of the chest will be held at the Sheraton
Hotel in Philadelphia, March 14-18, under the
sponsorship of the American College of Chest
Physicians and the Laennec Society of Philadel-

Tnition, including daily luncheons and the banquet on March 14, will be \$75 for members of the A.C.C.P. and \$100 for non-members. The number of registrants for the course are limited, and applications will be accepted in the order in which they are received. Address the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

AMERICAN ACADEMY OF ARTS AND SCIENCES

The American Academy of Arts and Sciences has announced three one thousand dollar prizes to be awarded annually to the authors of unpublished monographs—one each in the fields of the humanities, social sciences, and physical and biological sciences.

The final date for receipt of manuscripts by the committee on awards is October 1, 1960. Full details may be secured on request by sending a stamped self-addressed envelop to the Committee on Monograph Prizes, American Academy of Arts and Sciences, 280 Newton Street, Brookline Station Boston 46. Massachusetts.

AMERICAN SOCIETY OF PSYCHOSOMATIC DENTISTRY AND MEDICINE. INC.

The annual meeting of the American Society of Psychosomatic Dentistry and Medicine will be held at the Shoreham Hotel, Washington, D. C., from Friday evening, March 11, to the afternoon of Sunday, March 13, preceding the District of Columbia Dental Society Meeting.

For detailed program, contact Dr. Jesse Caden, Chairman Program Committee, 5213 Connecticut Avenue, Washington 15, D. C.

INTERNATIONAL CONGRESS OF PHYSICAL MEDICINE

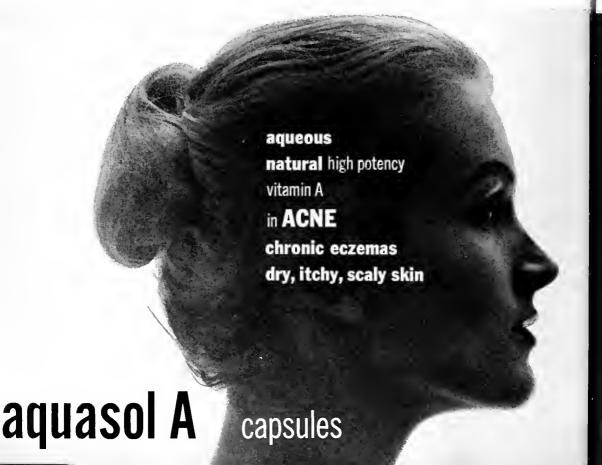
The Third International Congress of Physical Medicine will be held August 21-26, 1960, inclusive, at The Mayflower, Washington, D. C.

The preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, a scientific exhibit, a scientific film, etc. A copy of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

INTERNATIONAL MEDICAL ASSEMBLY

The twenty-fourth annual session of the International Medical Assembly of Southwest Texas will be held in San Antonio, Texas, January 25-27, 1960 at the Hilton Hotel.

Those interested in receiving further information or in registering may write Dr. A. O. Severance, President, or Mr. S. E. Cockrell, Jr., Executive Secretary, 202 West French Place, San Antonio 12, Texas,



WORLD FEDERATION OF NEUROLOGY

Inauguration of worldwide reporting of advances in the rapidly developing field of neurological sciences through its new official medical journal, World Neurology, has been announced by the World Federation of Neurology (WFN), international group representing neurology societies in 42 nations.

Scheduled for monthly publication beginning July, 1960, World Neurology medical papers will be printed in four languages—French, German, English and Spanish. Editorial offices will be in the United States, and the journal will be published by Lancet Publications, division of Modern Medicine Publications, Inc., Minneapolis, Minnesota.

Editor-in-chief is Dr. Charles M. Poser, University of Kansas School of Medicine, currently on leave as Medical Executive Officer to the World Federation.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Addition of unsaturated fats and oils to the otherwise unchanged ordinary diet will not reduce blood cholesterol and prevent heart attacks and strokes, the Food and Drug Administration said

recently. Representations to the public that salad oils, shortenings, eleomargarine, and similar products have value for these purposes are false and misleading and will cause such products to he mishanded, FDA declared in a statement of law-enforcement policy published in the Federal Register.

About 87 million Americans have now had at least one shot of polio vaccine and 68 million have had three or more injections, according to new estimates announced today by the Public Health Service.

The figures were released during a day-long meeting of representatives of health and medical organizations who were called to Washington by the Public Health Service to review the 1959 polio experience and to map out ways of promoting further vaccinations before next summer.

Among persons under 40, more than 34 million, or almost 30 per cent, have had no vaccine. Among children under 5 years of age, the group that accounted for 43 per cent of the paralytic cases this year, four and one-half million have had no vaccine.

An analysis of the 1959 polio experience Disease showed that the vaccine had proved to be at least 90 per cent effective this year in protecting persons who had had three or more doses.

(Continued on page 44)

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 Davirtson, D. D. and Schol, A. E.: J. Invest. Form. 12-221, 1949.

BOOK REVIEWS

The Modern Family Health Guide. Edited by Morris Fishbein, M.D. 1001 pages. Price, \$7.50. New York: Doubleday & Company, Inc., 1959.

This book is the most satisfactory work of its kind that this reviewer has seen. The first 398 pages are devoted to a discussion of the basic modern concepts about health and disease: diet, diseases of special systems, medical statistics, and various periods of life, from infancy to old age.

The next 600 pages give in alphabetical order definitions of medical terms, followed by a comprehensive index. Care has been taken to integrate the contents of the book so as to avoid unnecessary duplication and yet give specific answers to questions in the reader's mind.

The language in the whole book is as clear as it can be without sacrificing accuracy. The medical advice given is sound, and should neither alarm the reader nor lead him to unwise self-diagnosis and self-medication.

The book represents the combined effort of 27 contributors, each an authority in his field. It reflects the editorial genius of the veteran medical editor, Dr. Morris Fishbein. It deserves the much overworked term of "a monumental contribution," which any doctor can cheerfully recommend to his patients as a reliable source of medical information.

Jewish Medical Ethics. By Immanuel Jakobovitch. \$6.00, 381 pages. New York: Philosophical Library, 1959.

The choice between moral autonomy or moral automation is the most fateful alternative confronting mankind today, says Rabbi Jakobovitch, who in this book has given us the first comprehensive treatise on the subject of Jewish medical ethics. No longer is the contest between science and religion a competitive search for truth, but rather a struggle between the supremacy of man's creations and the supremacy of man himself. The perplexities of our age call for a renewal of the ancient partnership between medicine and religion.

This book is therefore a welcome addition to the literature of medical ethics which in the past has been heavily dominated by the contributions of Catholic moralists. The author does not confine himself to Jewish law since his historical approach necessitates tracing the religious views of medicomoral problems from antiquity to the present day. He frequently alludes to and summarizes Catholic and Protestant opinions on such controversial topics as eugenics, sterilization, abortion, euthanasia, and post-mortem examination. As is the case with most legal discussions, this book is a compilation of opinions, although this may be partly due to the fact that the book is an ougrowth of a

1955 doctoral dissertation at the University of London. Approximately one third of the book is devoted to documentation, with the notes and references being given at the end of the book. There is an exhaustive bibliography of ancient and modern Jewish medical writings and a good general bibliography on medical ethics, but no index. There is a type-setting error involving the duplication of two lines of type on page 174 and there is a minor historical error in the dating of Tertullian 200 years after rather than before Augustine (page 137).

The author recognizes that the decisions featured in this book are mainly historical and cannot be used as practical directives either by patients, doctors, or theologians apart from an examination of the facts in each individual case. Nevertheless the author has succeeded in providing an introduction to teachings in an area where the three most vital disciplines of life—religion, law and medicine—meet and often overlap. The book will be warmly received by all interested in the history of medicine and by those who seek to understand the contribution which religion can make as a guide to moral conduct in an often-perplexing scientific age.

British Scientist Cites Versatility of Aspirin

The remarkable therapeutic versatility of aspirin was the theme of a talk given by Dr. James Reid of Western Infirmary, Glasgow, Scotland, at the December seminar sponsored by the Sterling-Winthrop Research Institute.

In addition to describing aspirin's varied medical uses, Dr. Reid also advanced certain hypothese concerning its mode of action. Medical science still has not resolved the problem of how aspirin actually relieves pain, reduces fever, eases inflammation on the rheumatic diseases, etc.

Dr. Reid discussed his own clinical experiences, reported in British medical journals, which demonstrated that aspirin is effective in the treatment of diabetes. Its value in rheumatic fever, myxoedema and other diseases was also outlined.

The Common Cold

The 'common cold'—our number one acute respiratory disease—is as puzzling as it is prevalent, with the cause still unknown in about 50 per cent of cases, according to a recent issue of Patterns of Disease, a publication prepared for and distributed to the medical profession by Parke, Davis & Company.

Many viral agents are incriminated in 'coldlike illness' but it "is possible that a continuing search for the etiologic agent will identify one specific virus as the cause of many colds," the publication says. Specific immunity to reinfection recently has been demonstrated in human volunteers by direct challenge experiments.

The Month in Washington

Congress embarked on a crucial election year session with expansion of the Social Security program shaping up as one of the major issues.

It was virtually a foregone conclusion that some liberalization of the program would be voted in the Democratic-controlled Congress, but the key question was how far the changes would go. In every Presidential election year during recent years, the House and Senate have approved a broadening of the program.

One of the prime reasons Social Security has been an election year "favorite" is that the program can be boosted without affecting the Federal budget. This is because it is financed through employer-employe contributions and is theoretically self-supporting.

Of special interest to physicians, of course, is the fate of the so-called Forand bill that would provide hospitalization, surgical services, and nursing home care for Social Security beneficiaries. This would be accomplished through even higher taxes on employes and employers than now scheduled through already-voted step increases.

Supporters of the controversial legislation—vigorously opposed by the Administration, the American Medical Association, and allied organizations—launched their move to win enactment this session.

Senator Pat McNamara, (D., Mich.). whose Senate Subcommittee on Aging held a series of hearings across the country during the recess, announced at the conclusion of the hearings that they showed a need for expanding Social Security to include health care for the aged. He indicated that he thought the Forand bill did not go far enough.

A battery of speakers at a meeting here of the American Public Welfare Association also urged a sharp increase in benefits, with some advocating "cradle to grave" security for all.

Not all of the proposals for extending the program involved health care.

The Administration indicated it would recommend some expansion, especially in the disability program under which the

From the Washington Office of the American Medical Association.

Federal government helps the states provide assistance to persons over age 50 judged to be totally and permanently disabled. An influential lawmaker, Representative Burr Harrison (D., Va.), disclosed that he would introduce legislation to remove the age 50 limitation to allow all persons regardless of age to participate. He estimated this would not require any hiking of the taxes. Representative Harrison is chairman of a House Ways and Means Subcommittee that held recess hearings on administration of the disability program.

Meanwhile, Chairman Wilbur Mills (D., Ark.) of the full Ways and Means Committee cleared the way for full-scale hearings this Congressional session on the entire issue of Social Security. In listing specific phases to be considered, however, the law-maker did not mention the Forand proposal.

A spokesman for the American Medical Association told the Federal Communications Commission that the A.M.A. believes the best solution to objectionable advertising and programs on television and radio is for the industry "to clean its own house."

Dr. Eugene F. Hoffman, co-chairman of the A.M.A.'s Physician's Advisory Committee on Television, Radio and Motion Pictures, declared "the medical profession... stands ready to assist the networks and individual stations in determining accuracy and good taste of broadcast material involving health or medicine—either commercial or public service."

Serial X-ray Films with Hypaque Called Useful in Arteriography

The technique of cineroentgenography combined with image amplification, using the contrast agent Hypaque, offers considerable advantage in demonstrating changes in velocity of blood flow in diseased peripheral vessels which are not completely occluded, two investigators state in Connecticut Medicine (23:573, 1959).

The procedure is described by Drs. Robert M. Lowman and Seymour Haber, Yale University School of Medicine. Its specific advantage "is the ability to time the passage of the dye from its site of injection to the site of occlusion, with ease." Viewing is simplified by use of the image amplifier, they say, adding that the same thing can be done by employing routine fluoroscopic apparatus.

BULLETIN BOARD

(Continued from page 41)

Clinical Center Study on Thyroid Cancer

The cooperation of physicians in nearby areas is requested in a study of carcinoma of the thyroid gland being conducted by the Radiation Branch of the National Cancer Institute in the Clinical Center of the National Institutes of Health, Bethesda, Maryland. This study has as its primary purpose a search for therapeutic methods which may favorably affect the course of this disease.

This study has three major components. The first two components are concerned with the relationships of structure and function of tumor components to hormonal influences and to the uptake of radioactive iodine. The third component is related to the study, development, and detection of autoimmune antibodies developed to the patient's own thyroid gland and thyroid cancer as the antigen and the possible response of thyroid cancer to this antigen.

Patients appropriate to this program will be those in whom the diagnosis of cancer of the thyroid is established and who present either without prior treatment or with demonstrable persistent or recurrent disease after prior treatment. Patients should not be in the terminal phase of the disease as such a circumstance allows no followup period for the determination of results. Accepted patients will be studied for various periods of time and may be followed subsequently by either the referring physician or physicians at the Clinical Center. A comprehensive and individual program will be instituted for each patient and will include appropriate supportive and symptomatic

care as well as the experimental therapy study described above.

Physicians interested in the possibility of referring such patients should write or telephone: Charles G. Zubrod, M.D.

Clinical Director National Cancer Institute Bethesda 14, Maryland (OLiver 6-4000, Ext. 4346)

or J. Robert Andrews, M.D. Chief, Radiation Branch National Cancer Institute Bethesda 14, Maryland (OLiver 6-4000, Ext. 3351)

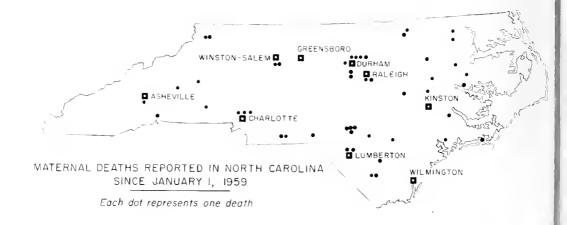
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WANTED: Male psychiatrist; Diplomate or with three years approved training; to join group practice 145-bed approved psychiatric hospital. Salary: \$15,000-\$18,000 first year; \$20,000-\$25,-000 second with incentive factor. Write Box 790 care this Journal, Raleigh, N. C.

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Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persist ent failure to gain weight.

In this study, the weight gained was not lost

after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in I cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

^{*}Brown, S. S.; Liba, H. W., and Nussbaum, A. H.: Narethondrolane in the Successful Management of Anaroxia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.



bring all of her concepts of cleansing

Many women don't know that a vinegar douche is as old-fashioned as the copper tub, a relic of an empiric age. Acids actually make mucus discharge more tenacious. On the other hand, soaps and harsh alkali are irritating. A detergent douche — TRICHOTINE, the only major douche containing sodium lauryl sulfate — is the modern, more

efficient yet gentler vaginal irrigant.

The detergent action of TRICHOTINE assures greater penetration of viscid mucus, better dispersion of the healing medicaments on the mucosal surface, and more efficient removal of vaginal discharge.

If there is any doubt in your mind, compare TRICHOTINE with vinegar or any other

Goodman, L.S. and Gilman, A.: The Pharmacologic Basis of Therapeutics, MacMillan, 1955.



... up to date with TRICHOTINE

solution in your office clean-up. You will see readily the advantages of TRICHOTINE. It will prove equally desirable for home douching.

The pH changes produced by any low pH douche last only a few minutes² and are of questionable value in healing.³ TRICHOTINE actually favors epithelial growth and

healing, 3 assures maximum cleansing, soothes inflamed mucus membranes.

TRICHOTINE is indicated in the management and treatment of cervicovaginitis and leukorrheas, alone or in conjunction with other antimicrobials. TRICHOTINE is ideal for routine feminine hygiene — safe, gentle and effective.

The Fesler Company, Inc.

375 Fairfield Avenue, Stamford, Connecticut

^{2.} Karnaky, K.J.: J.A.M.A. 157:1155, 1955 (August)

^{3.} Scheinberg et al: Surgery 24:972, 1948 (Dec.),



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ACETYL PEDIATRIC SUSPENSION

N1 Acetyl Sulfamethoxypyridazine Lederte

just 1 dose a day ... achieves rapid therapeutic levels ... sustained for 24 hours ... extremely low incidence of sensitivity reactions and renal complications . . . convenient, highly economical . . .

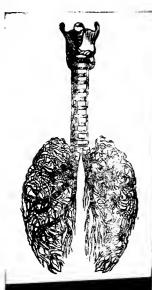
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Recommended dosage: first-day dose is 1 teaspoonful (250 mg.) for each 20 lbs. body weight up to 80 lbs. For each day thereafter, ½ teaspoonful for each 20 lbs. For 80 lbs. and over, use adult dosage of 4 teaspoonfuls (1.0 Gm.) initially, and 2 teaspoonfuls (0.5 Gm.) daily thereafter. Administer immediately after a meal.

Supplied: Each teaspoonful (5 cc.) contains 250 mg. of sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.



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an <u>added</u> measure
of protection in your
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SULTUSSIN triple sulfonamides add their antibacterial power to your choice of antibiotic to

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SULTUSSIN simultaneously affords maximum relief from sneezing, stuffed or runny nose, cough, wheezing, malaise, slight fever, and other distressing symptoms of the severe common cold, coughs, influenza, etc.

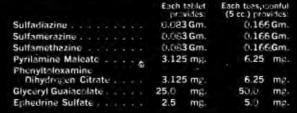
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Foods can provide many minerals needed for control of body functioning . . . as well as for structure of body tissues . . . but special consideration needs to be given to insure that the diet contains enough of certain minerals.

The minimum quantities of foods listed in A Guide to Good Eating can provide most of the Recommended Dietary Allowances for

calcium . . . 2/3 from milk group . . . and 1/4 from other groups.

iron . . . 1/3 from meat group . . . 1/4 fram vegetables and fruits . . . and 1/5 from enriched breads ond cereals.

Calcium is essential to normal blood clotting, muscle contraction, nerve functioning and cell permeability . . . in addition to its main role in the growth and maintenance of bones and teeth. Iron is used in the formation of hemoglobin, the red blood pigment which carries life-giving oxygen from the lungs to body cells. Phosphorus . . . which plays a vital part in the energy metabolism of cells as well as in formation of bony tissues . . . is provided by foods in all four groups . . . especially those which supply calcium and protein. Potassium, sodium and chlorine are involved with maintaining water balance in the body. Potassium is abundant in animal and plant foods ... sodium and chlorine are present in foods and table salt. Copper, cobalt, magnesium, manganese, molybdenum and zinc take part in various enzyme reactions . . . and are supplied in needed amounts

DAIRY FOODS

3 to 4 glesses milk-children • 4 or more glassesteenagers . 2 or more glesses -adults . Cheese, ice cream and other milk-made foods can supply part of the milk

MEAT GROUP

2 or more servings . Meets, fish, poultry, eggs, or cheese - with dry beans, peas, nuts as alternates

VEGETABLES AND FRUITS

4 or more servings . Include derk green or yellow vegetables; citrus fruit or tomatoes

BREADS AND CEREALS

4 or more servings . Enriched or whole-grain added milk improves nutritionel values

by foods listed in the "Guide."

Fluorine . . . not demonstrated to be a dietary essential...but shown to give developing teeth substantial protection from dental caries... is present in many foods and natural and treated water.

When combined in well-prepared meals, foods selected from each of those four food groups and seasoned with jodized salt can provide all needed minerals ... while satisfying the tastes, appetites and other nutrient needs of all members of the family . . . young and old.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

Since 1915...promoting better health through nutrition research and education.



NATIONAL DAIRY COUNCIL

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This information is reproduced in the interest of good nutrition and health by the Dairy Council Units in North Carolina.

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build appetite with B complex



with ferric pyrophosphate, a form of iron exceptionally well-tolerated



Alcohol Bottles of '4 and 16 fl. oz.



25 mcgm.

promote protein uptake

with the potentiating effect of I-Lysine on low-grade protein foods



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Here is what you can expect when you prescribe

Case Profile*

A 28-year-old married woman, a secretary in a booking agency, complained of severe and consistent pain and cramps in the abdomen during her menstrual periods. Psychologically, she described the first two days as "climbing the walls." Menarche occurred at age 13. She has a regular twenty-eight day menstrual cycle and a four day menstrual period.

Trancopal was given in a dose of 100 mg. four times a day for the first two days of the four day period. In addition to the relief of the dysmenorrhea she also noticed disappearance of a "bloated feeling" that had previously annoyed her. She has now been treated with Trancopal for one and one-half years with excellent results. Other medication, such as codeine or aspirin with codeine, had relieved the pain, but the patient had had to stay home. Because her father is a physician, many commercial preparations had been tried prior to Trancopal, but no success had been achieved.

Before taking Trancopal this patient missed one day of work every month. For the past year and a half she has not missed a day because of dysmenorrhea.

for dysmenorrhea

and premenstrual tension



for low back pain



Case Profile*

A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg, three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

For the past six months, the patient has continued to take Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

*Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.

Turn page for complete listings of Indications and Dosage.

THE FIRST TRUE "TRANQUILAXANT"

potent MUSCLE RELAXANT

effective TRANQUILIZER

- In musculoskeletal disorders, effective in 91 per cent of patients.¹
- In anxiety and tension states, effective in 89 per cent of patients.¹
 - · Low incidence of side effects (2.3 per cent of patients), Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
 - · No gastric irritation. Can be taken before meals.
 - · No clouding of consciousness, no euphoria or depression.

Indications 1-6

Musculoskeletal:

Low back pain (lumbago, etc.) Neck pain (torticollis) Bursitis Rheumatoid arthritis Osteoarthritis Disc syndrome

Fibrositis Ankle sprain, tennis elbow Myositis Postoperative muscle spasm

Psychogenic: Anxiety and tension states Dysmenorrhea Premenstrual tension Asthma Angina pectoris Alcoholism

Now available in two strengths:



Trancopal Caplets?, 100 mg. (peach colored, scored), bottles of 100.

NEW STRENGTH



Trancopal Caplets,

200 mg. (green colored, scored), bottles of 100. Dosage: Adults, 100 or 200 mg, orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Winthrop LABORATORIES New York 18, N. Y.

References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. Lichtman, A. L.: New developments in muscle relaxant therapy, Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.
 Lichtman, A. L.: Relief of muscle spasm with a new central Fract. J. 4:28, Oct., 1958. 3. Lichtman, A. L.: Renet of muscle spasm with a new central muscle relaxant, chlormezanone (Trancopal). Scientific Exhibit. Meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 4. Ganz, S. E.: Clinical evaluation of a new muscle relaxant (chlormethazanone). J. Indiana M. A. 52:1134. July, 1959. 5. Mullin, W. G., and Epifano, Leonard: Chlormezanone, a tranquilizing agent with potent skeletal muscle relaxant properties, Am. Pract. Digest Tract. 10:1743. Oct., 1959. 6. Shanaphy, J. F.: Chlormezanone (Trancopal) in the treatment of dysmenorrhea; a preliminary report, Current Therap. Res. 1:59. Oct., 1959.

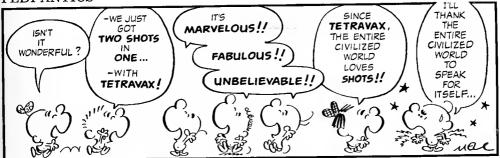
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DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more diseases...with fewer injections

Supplied: 9 cc. vials in clear plastic cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



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when self-medication has delayed medical attention...

...and has risked upper respiratory complications



COSA-TETRACYDIN CAPSULES

Cosa-Tetracyn® - analgesic - antihistamine compound

act quickly to

- control secondary infection
- alleviate cold symptoms

each capsule contains:

 Cosa-Tetracyn
 125 mg.

 phenacetin
 120 mg.

 caffeine
 30 mg.

 salicylamide
 150 mg.

 buclizine HCl
 15 mg.

average adult dose: 2 capsules q. i. d.





In a nutshell our story is this. We have released a brand new strength of Honey Cillin with a brand new flavor and appearance . . . It is designated . . . Honey Cillin "400" (RED). Each 5cc teaspoonful contains 400,000 units of Penicillin G. Potassium . . . Your patients whether they be tiny tots or "finicky" adults, will enjoy the pleasing taste afforded by the new cherry and honey flavor combination. They will like its sparkling red color . . . they will be delighted by its reasonable price.

The other half of our story is this: Honey Cillin '300' also is still available (300,000 units per 5cc, honey flavor, yellow color) . . . and we would like to remind you, too, of our Trifonacil-250 . . . a most excellent choice when your patient requires penicillin plus triple sulfa pyrimidines in combination with 250,000 units Penicillin G. Potassium strawberry flavor. All three products are packaged in 60cc size bottles.



WHEN BLOOD PRESSURE MUST COME DOWN...



When hypertensive symptoms such as dizziness, headache and fainting are frequent enough and severe enough to interfere with your patient's activity and safety-then it is time to consider the beneficial actions of Serpasil-Apresoline. Both Serpasil and Apresoline lower blood pressure. When the Serpasil-Apresoline combination tablet is prescribed, blood pressure response is even better. In addition, Serpasil contributes favorable calming and heartslowing effects. Apresoline increases renal blood

flow, decreases cerebral vascular resistance and inhibits the actions of humoral pressor agents. Combined with Serpasil, Apresoline is effective at a lower dosage, thus side effects are rarely a serious problem.

SUPPLIE: Tablets #2 (standard-strength), each containing 0.2 mg. of Serpasil and 50 mg. of Apresoline. Tablets #1 (half-strength), each containing 0.1 mg. of Serpasil and 25 mg. of Apresoline. Samples available on request,

hydrochloride (reserpine and hydralazine hydrochloride CIBA)

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CLINICAL BRIEFS FOR MODERN PRACTICE

WHY IS DIABETES IN INFANTS SO DIFFICULT TO DIAGNOSE?

Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes 8:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."* the standardized urine-sugar test for reliable quantitative estimations



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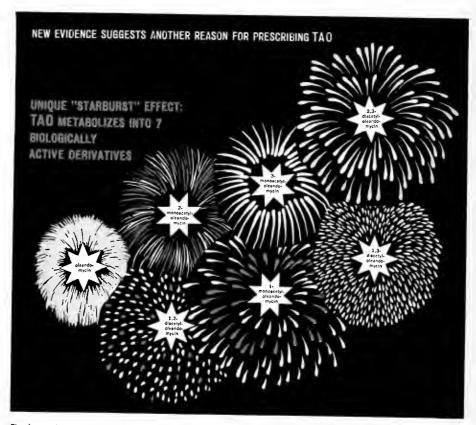
DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110 Patients

Symptoms	No. of Patients	Per cent of total group
	-	
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	2S.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
8oils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and Newcomb A L.*

- · full-color calibration, clear-cut color changes
- · established "plus" system covers entire critical range
- standard blue-to-orange spectrum
- · standardized, laboratory-controlled color scale
- · "urine-sugar profile" graph for closer control



The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of in vivo and in vitro biological and biochemical evaluations that show TAO to be indeed unique.1.2

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which remain active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of Staph. aureus.

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenical was active against 52%; erythromycin against only 25%) • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

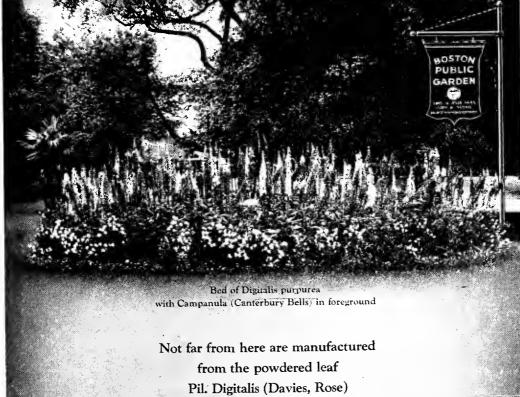
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Supplied: TAO Capsules $-250~\rm mg$, and $125~\rm mg$, bottles of 60, TAO for Oral Suspension $-125~\rm mg$, per tsp. (5 cc.) when reconstituted; unusually patatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Orops: flavorful, easy to administer. TAO®AC: TAO analgesic, antihistaminic compound. TAOMIO®: TAO with triple sulfas. Intramuscular or intravenous: in clinical emergencies. Prescription only.

English, A. R., and McBride, T. J.: Proc. Soc. Exper. Blol, & Med. 100-880 (Apr.) 1959.
 Celmer, W. O.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277.
 English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8420 (Aug.) 1958.





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this preparation comprises the
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means of digitalizing the cardiac patient
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meprobamate cases tensions of dieting

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Each coated tablet (pink) contains: d-amphetamine sulfate5 mg. meprobamate400 mg. Dosage: One tablet taken one-half to one hour before each meal



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Acetophenetidin gr. $2\frac{1}{2}$ Acetylsalicylic Acid . . . gr. $3\frac{1}{2}$ Caffeine gr. $\frac{1}{2}$

'TABLOID'

EMPIRIN' COMPOUND

WITH

CODEINE PHOSPHATE*

Acetophenetidin gr. 2½
Acetylsalicylic Acid . . . gr. 3½
Caffeine gr. ½
Coderne Phosphate . gr. ½

No. 2

Acetophenetidin ... gr. 2½

Acetylsalicylic Acid ... gr. 3½

Caffeine ... gr. ½

Codeine Phosphate ... gr. ½

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Acetylsalicylic Acid ... gr. 3½
Caffeine ... gr. ½
Codeine Phosphate ... gr. ½

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IN

simple headache rheumatic conditions arthralgias myalgias

toothache earache dysmenorrhea neuralgia

common cold

minor trauma tension headache premenstrual tension minor surgery post partum pain

organic disease neoplasm

trauma

muscle spasm

migraine musculo skeletal pains postdental surgery post partum involution

fractures synovitis bursitis

relief of pain of all degrees of severity up to that which requires morphine

AND IN fevers dry,

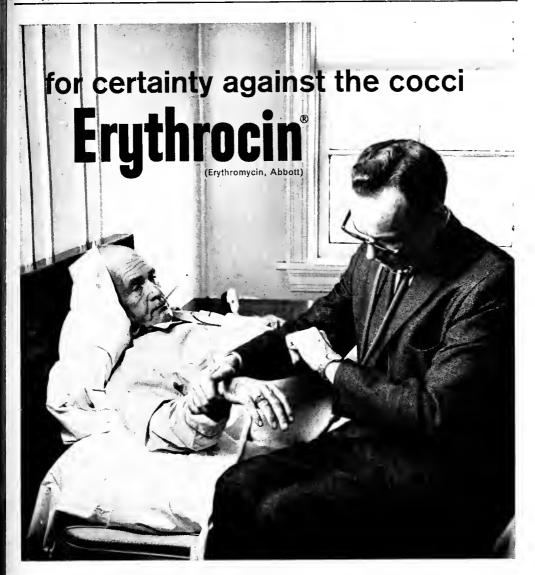
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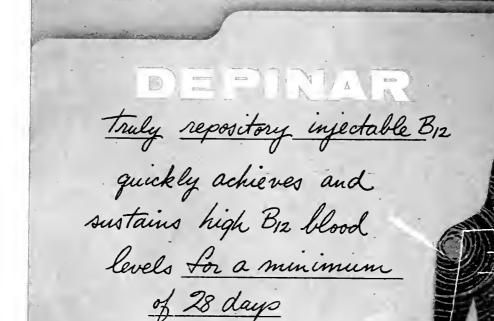
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*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

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safe and effective for patients of all ages suffering from respiratory tract congestion

	DOSAGE	,	
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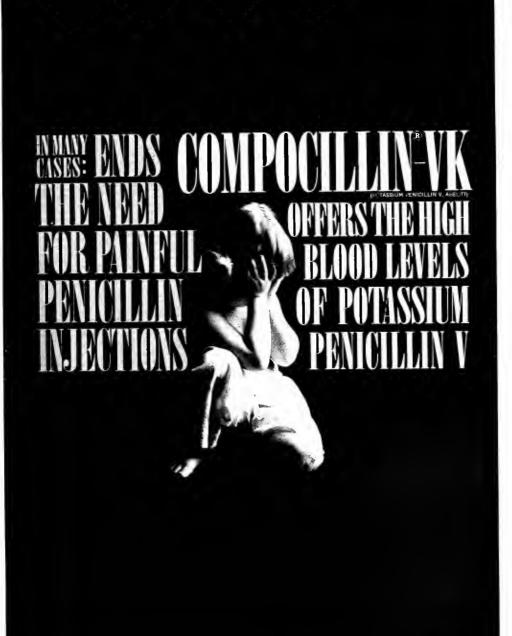
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Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953.
 Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955.
 Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956.
 Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Cliaical Meeting (Scientific Section, Exhibit No. 124), Miaaeapolis, Minnesota, Dec. 2-5, 1958.

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Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958.

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Cramer, Quentia (Kansas City): Missouri Med. 55:1203, Nov., 1958.



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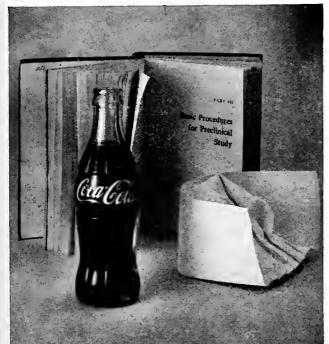
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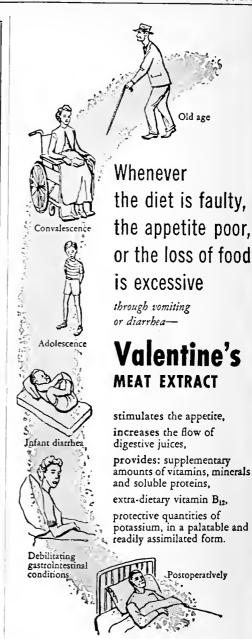
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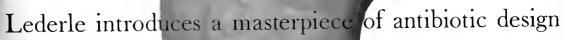
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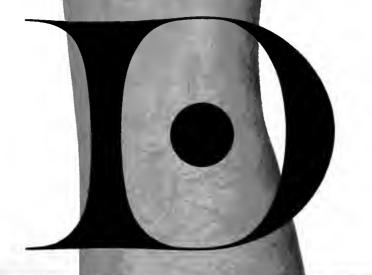
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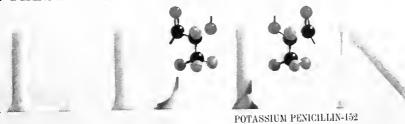
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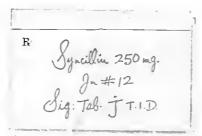
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Significance of complementary action of isomers in SYNCILLIN The antibiotic effect of the clinically available mixture. SYNCILLIN. is greater than that of either of its two component isomers alone against many important pathogens. including some penicillinresistant staphylococci. This phenomenon has been described as Isomeric Complementarity.

Significance of higher blood levels with SYNCILLIN Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms Studies have shown that SYNCILLIN is effective in vitro against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%. Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal³ and gonococcal^{4, 5} infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



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luced rate of inactivation YNCILLIN by staph peniciltinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G. Penicillinase from B. cereus likewise inactivates SYNCILLIN less rapidly than penicillin V and G. But this would not impede the therapeutic use of this penicillinase in allergic reactions. This is because the massive dosage with which this enzyme is administered would effectively destroy SYNCILLIN in the body.

References: 1. Wright, W. W.: Mirrobiology Report to Bristol Laboratories Inc. 2. Kligman, A.; Morigi, E. M. E.; Whealey, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, Washington, D.C. 3. Editorial: New England J. Med. 261:305 (Aug. 6) 1959. 4. King, A.: Lancet 1:651 (March 29) 1958. 5. Epstein, E.: J.A.M.A. 169:1055 (March 2) 1959. 6. Kass, E. H.: Am. J. Med. 18:764 (May) 1955. 7. Eagle, H.: J. Bact. 58:475, 1949.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gomococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILIN, like other or all penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or sphilis.

Dasage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections, SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. Therefore, the usual precautions for oral penicillin therapy should always be observed. Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals. Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages. If superinfection occurs during therapy, appropriate measures should he taken. Since some strains of staphylococci are resistant to SYNCILLIN

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CARISOPRODOL

*MYOGESIC muscle relaxant - analgesic Schering



makes the cancer patient more comfortable

- reduces impact of pain
- decreases narcotic requirements
- · increases appetite
- improves mental outlook

NIAMID lessens the need for narcotics in the depressed cancer patient and appears to potentiate pain-relieving agents. As pain is reduced and mental outlook improves, apprehension and depression are replaced by a brighter and more alert attitude, and appetite returns. The family, too, is cheered by the improvement in the patient's condition. With NIAMID therapy, patient care becomes noticeably less demanding.

Supply: NIAMID (brand of nialamide) is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

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NIAMID

the mood brightener in cancer



Science for the world's well-beingth





relief comes fast and comfortably

-does not produce autonomic side reactions -does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

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New...conservative treatment for muscle and joint disease

- potent...fast relief in acute conditions
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SOMA RELIEVES PAIN in a unique way by modifying central perception of pain without abolishing natural defense reflexes.

SOMA RELAXES MUSCLE SPASM . . . approximately 8 times more potent than meprobamate or mephenesin.

PHYSICIANS'

REPORTS:

"Marked pain-relieving effects of the new drug [Soma] were seen in conditions involving muscle spasm and stiffness, whether acute or chronic. Relief from pain was usually rapid and sometimes dramatic." (90 patients.) Kuge, T.: Submitted for publication.

"In 86 percent of the patients there were excellent or good results. . . . Relief of pain was noted by the patients' statements, by the diminished need for analgesic drugs, and by improved sleep." (154 patients.)

Wein, A. B.: The Use of Carisoprodol in Orthopedic Surgery and Rehabilitation. Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol. Wayne State University Press, Detroit, 1959, p. 156.

In a double-blind study, Soma was reported to be "clinically effective to a highly significant degree." (92 patients.)

Cooper, C. D., and Epstein, J. H.: The Clinical Evaluation of Carisoprodol by a doubleblind technique. Ibid. p. 97.

Natable safety-extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosage

Rapid action—starts to act quickly

Sustained effect-relief lasts up to 6 hours

Easy to use-usual adult dose is one 350 mg. tablet 3 times daily and at bedtime

Supplied—as white, coated, 350 mg. tablets, bottles of 50. Also available for pediatric use: 250 mg. orange capsules, bottles of 50.



BIBLIOCRAPHY: 1. Berger, F.M., Kletzkin, M., Ludwig, B.J., Margolin, S. and Powell, L. S.: J. Pharm. Exp. Ther. 127:66 (Sept.) 1959. 2. Leake, Chauncey D.: Proceedings of the Symposium on The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959, p. 8. 3. Kestler, Otto: Ibid. p. 143. 4. Proctor, Richard C.: Ibid. p. 122. 5. Berger, Frank M., Ibid. p. 25. 6. Goodgold, Iboseph, Hobmann, Thomas and Tajuma, Toshihiro: Ibid. p. 60. 7. Gammon, George D. and Tucker, Samuel: Ibid. p. 70. 8. Baird, Henry W. and Menta, Dominic A.: Ibid. p. 85. 9. Cooper, C. David and Epstein, Ironome H.: Ibid. p. 97. 10. Korst, Donald R., Gerard, R. W., Miller, James C., Small, Iver F., Grahsm, I. J. and Winkelman, Eugene I: Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 115. 12. Trimpi, Howard D.: and Winkelman, Eugene I: Ibid. p. 104. 11. Friedman, Arnold P.: Ibid. p. 11S. Ibid. p. 150. 13. Wein, Arthur B.: Ibid. p. 156. 14. Olds, James and Travis, R. P 14. Olds, James and Travis, R. P.; Ibid. p. 39. 101d. p. 130.

Eckhard H., Polt, James M. and Goodwin, Elizabeth: Ibid. p. 51.

16. Phelps, Winthro, Spears, Catherine E.; Ibid. p. 138.

18. Hyde, L. P. and Hough, Charles E.; Ibid. p. 166. 16. Phelps, Winthrop M.: Ibid. p. 131. Ecknard 11., Folt, James 31. and 30000001. Classified in the Charles E.: Ibid. p. 166. 19. Spears, Catherine E. ibid. p. 138. 18. Hyde, L. P. and Hough, Charles E.: Ibid. p. 166. 19. Spears, Catherine E. and Phelps, Winthrop M.: Arch. Pediat., 76:247 (July) 1959. 20. Phelps, Winthrop M.: Arch. Pediat., 76:243 (June) 1959. 21. Friedman, Arnold P.: Paper presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 22. Frankel, Kalman: Ibid. 23. Fransway, Robert L.: of Industrial Medicine, Inc., New York, Sept. 30, 1959. Ibid. 24. Kuge, T.: Unpublished reports.

ANNOUNCING SCHERING'S NEW MYOGESIC^x





Lifts depression..



as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... swiftly and safely

Balances the mood - no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient - they often aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation - they often deepen depression.

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety - both at the same time.

Acts swiftly - the patient often feels better within a few days. Unlike the delayed action of other drugs which may take two to six weeks to bring results, Deprol's smooth, immediate action relieves the patient quickly - often within a few

Acts safely - no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function frequently reported with other drugs.

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BIBLIOGRAPHY (10 clinical studies, 714 patients):

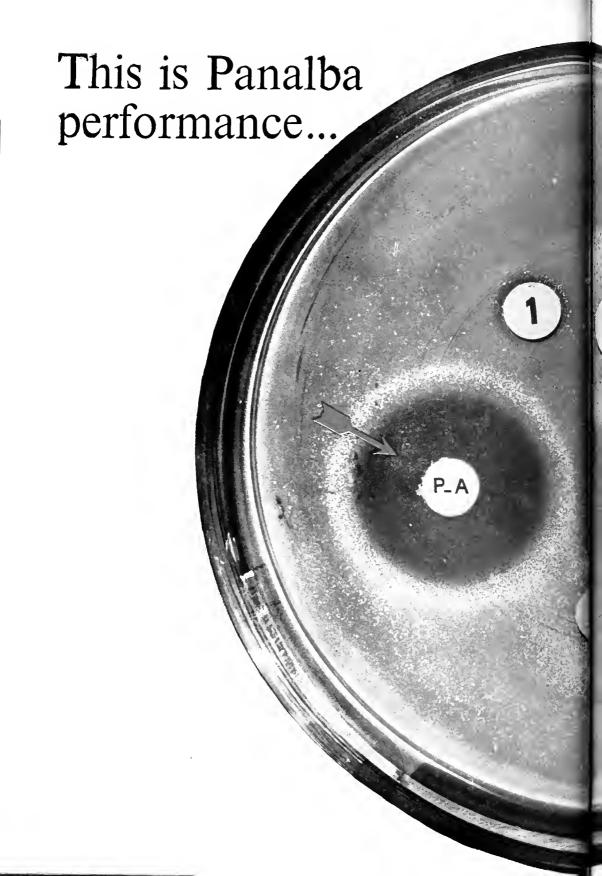
1. Alexander, L. (35 patients): Chemotherapy of depression — Use of meprobomatic combined with benactyzine (2-detelydominaethyl benzilate) hydrochloride. J.A.M.A. (26,1019, March 1, 1958, 2, Bateman, J. C. and Cortian, H. M. (50 obtients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced concer. Antibiatic Med. & Clin. Therapy 0.648, Nov. 1959, 3, Bell, J. L., Touber, H., Sonty, A. and Pulita, F. (77 patients): Treatment of depressive states in offlice practice, Dis. Nerv. System 20,263, June 1959, 4, Breiner, C. (31 patients): On mental depressions. Dis. Nerv. System 20,142, (Section Two), May 1959, 5. McClure, C. W., Papas, P. N., Spoere, G. S., Polmer, E., Slattery, J. J., Kanelal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression—New technics and therapy. Am. Pract. & Digest Treat, 10,1525, Sept. 1959, 6. Pennington, V. M. (135 patients): Preatment of depression—New technics and therapy. Aug. 1959, 7. Riccles, K. and Ewing, J. H. (135 patients): Deprol in depressive conditions, Ois. Nerv. System 20,364, (Section One), Aug. 1959, 7. Riccles, K. and Ewing, J. H. (135 patients): Deprol in depressive conditions, Ois. Nerv. System 20,364, (Section One), Aug. 1959, 8. Ruchwarger, A. (187 patients): Use of Deprol (meprobamate combined with benoctyzine hydrochloride) in the elderly with a meprobamate-benactyzine hydrochloride combination, Antibiotic Med. & Clin. Therapy, In press, 1959, 10, Splitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.

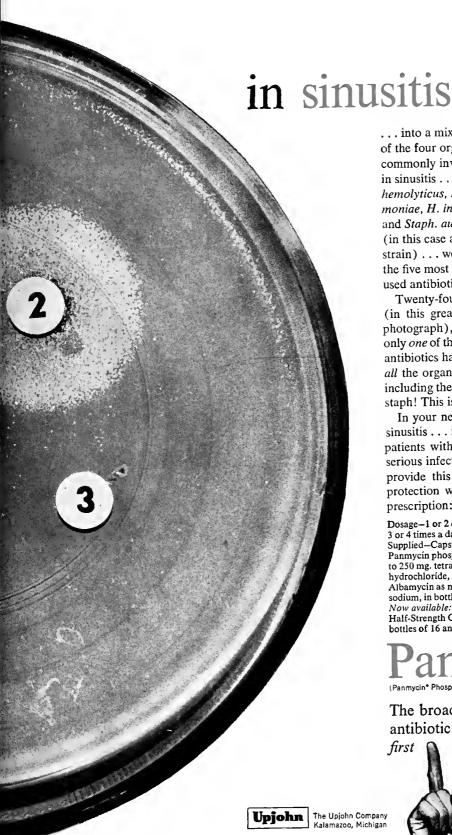
Deprol



Dosago: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d. Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

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... into a mixed culture of the four organisms commonly involved in sinusitis . . . Str. hemolyticus, D. pneumoniae, H. influenzae and Staph. aureus (in this case a resistant strain) ... we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only one of the five leading antibiotics has stopped all the organisms, including the resistant staph! This is Panalba.

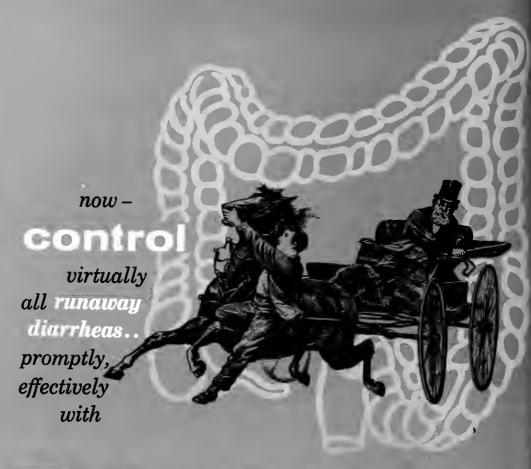
In your next patient with sinusitis . . . in all your patients with potentiallyserious infections ... provide this extra protection with your prescription:

Dosage-1 or 2 capsules 3 or 4 times a day. Supplied-Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100. Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

The broad-spectrum antibiotic of a resort first

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Donnage with Neomycin

Prompt and more dependable control of virtually all diarrheas can be achieved with the comprehensive Donnagel formula, which provides adsorbent, demulcent, antispasmodic and sedative effects—with or without an antibiotic. Early re-establishment of normal bowel function is assured—for all ages, in all seasons.

DONNAGEL: In each 30 cc (1.6 or).

OHITAGEE. III Editi 30 EE.	(1 11. OZ.):
Kaolin (90 gr.)	6.0 Gm.
Pectin (2 gr.)	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Phenobarbital (1/, gr.)	16.2 mg

DONNAGEL WITH NEOMYCIN

Synonyms for Pain Relief...

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EMPIRIN' Compound°

	Acetophenetidin			gr.	21/2
	Acetylsalicylic Acid			gr.	$3\frac{1}{2}$
-	Caffeine			gr.	1/2

TABLOID'

EMPIRIN' Compound°

WITH

CODEINE Phosphate*

NU. I	Acetophenetidin Acetylsalicylic Acid Caffeine Codeine Phosphate	gr. 3 ¹ , gr. ¹ ,
No. 2	Acetylsalicylic Acid Caffeine	gr. 3½ gr. 3
No. 3	Acetophenetidin Acetylsalicylic Acid Caffeine Codeine Phosphate	gr. 3½ gr. ½
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Acetylsalicylic Acid gr. 31/2

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...providing the desired gradation of potencies for result of varying intersities of pain

simple headache rheumatic conditions arthralgias myalgias common cold toothache earache dysmenorrhea neuralgia minor trauma tension headache premenstrual tension minor surgery post-partum pain trauma organic disease neoplasm muscle spasm colic migraine musculo-skeletal pains postdental surgery post-partum involution fractures synovitis bursitis

relief of pain of all degrees of severity up to that which requires morphine

AND IN fevers

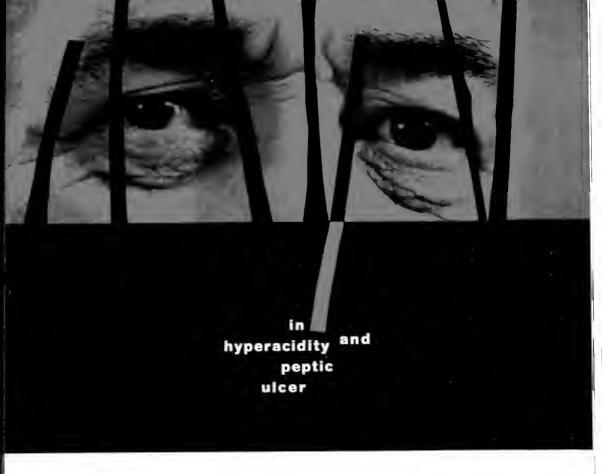
dry, unproductive coughs

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as reactive in tablet form . . .



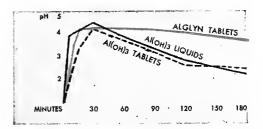


Dihydroxy aluminum aminoacetate

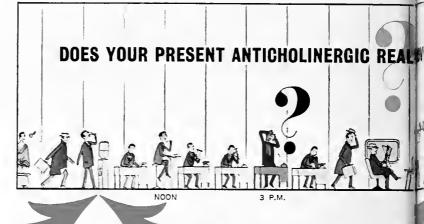
The superiority of Alglyn (dihydroxy aluminum aminoacetate) as an antacid over ordinary aluminum preparations is quite pronounced. Not only do Alglyn Tablets act as rapidly as aluminum hydroxide gels and magmas, but they maintain a much more effective pH for a longer time (see chart).

Furthermore, Alglyn Tablets are decidedly superior when antacid-belladonna therapy is indicated. Ordinary aluminum preparations may actually adsorb as much as 80% of the spasmolytic drug, as compared to only 7% for Alglyn Tablets. In addition, Alglyn contains no sodium and less aluminum.

Supplied in bottles of 100 0.5 Gm. tablets. Also as Belglyn® (with belladonna), and as Malglyn® (with belladonna and phenobarbital). Literature available upon request.







The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, even while he sleaps. The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied."

COMPARE THE DATA ON ENARAX...the new combination of an inherently long-acting anticholinergic (oxyphencyclimine) and Atarax, the non-secretory tranquilizer. Note the effectiveness of oxyphencyclimine:

DBSERVE THE OXYPHENCYCLIMINE REPORTS ...

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustainedaction anticholinergic in our study of this agent over a period of eighteen months."

Kemp: "...for the majority of patients, one tablet every 12 hours provided adequate control. This characteristic long action...may constitute an advantage of this drug as compared to coated 'long-acting' preparations of other compounds."3

Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

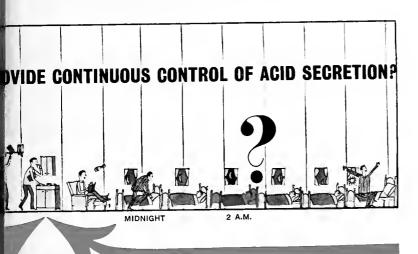
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Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that does.

ENARAX

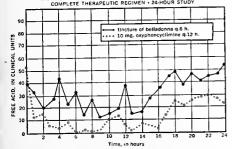
(oxyphencyclimine plus ATARAXS)

A SENTRY FOR THE G.I. TRACT



"Prolonged periods of achiorhydria" after 10 mg. oxyphencyclimine q. 12 h."

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING
COMPLETE THERAPEUTIC REGIMEN • 24-HOUR STUDY



Clinical Diagnosis: Peptic Ulcer — Gastritis — Gastroenteritis — Colitis — Functional Bowel Syndrome — Duodenitis — Hiatus Hernia (symptomatic) — Irritable Bowel Syndrome — Pylorospasm—Cardiospasm—Biliary Tract Dysfunctions—and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.

As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth..."

Each ENARAX tablet contains:



New York 17, N. Y. Division, Chas. Pfizer & Co., Inc. Science for the World's Well-Being™ control the tension-treat the trauma

...Pathibamate 400 200

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

mebrobamate (400 mg. or 200 mg.) widely accepted tranquilizer and ... PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: PATHIBAMATE-400 - Each tablet (yellow, 1/2-scored) contains

meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.

PATHIBAMATE-200 — Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: PATHIBAMATE-400-1 tablet three times a day at mealtime and

2 tablets at bedtime.

PATHIBAMATE-200-1 or 2 tablets three times a day at mealtime

and 2 tablets at bedtime.

Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder

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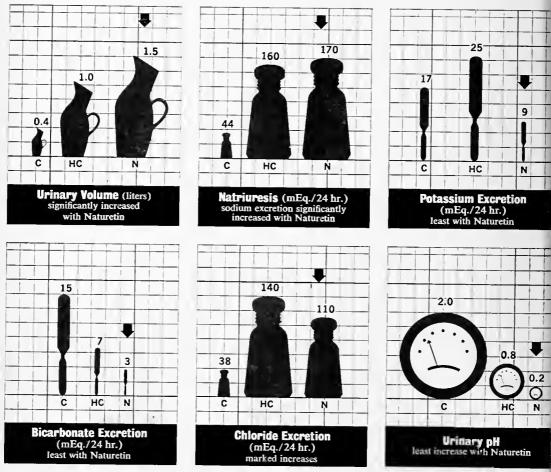


more closely approaches the ideal diureti-

Naturetin Squibb Benzydroflumethiazide

"When compared to other members of this heterocyclic gr of compounds, this drug [NATURETIN] shows a significantly creased natriuresis and decreased loss of potassium and bi bonate. In this respect it more closely approaches a natura 'ideal diuretic.' It is effective upon continuous administration causes no significant serum biochemical changes. It is effect in a wide variety of edematous and hypertensive states represents a significant advance in diuretic therapy." Ford, k Pharmacological observations on a more potent benzothiadia diuretic; accepted for publication by the American Heart Jour

Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Natureting



Typical Doses: Chlorothiazide-1,000 mg.; Hydrochlorothiazide-50 mg.; Naturetin (Benzydroflumethiazide)-5 mg.

A single 5 mg. tablet once a day provides all these advantages²

prolonged action — in excess of 18 hours convenient once-a-day dosage low daily dosage — more economical for the patient no significant alteration in normal electrolyte excretion pattern repetitively effective as a diuretic and antihypertensive greater potency mg. for mg.—more than 100 times as potent as chlorothiazide potency maintained with continued administration low toxicity — few side effects — low salt diets not necessary comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure and other favorable clinical effects purpura and agranulocytosis not observed allergic reactions rarely observed

²Reports (1959) to the Squibb Institute for Medical Research.

aturetin —Indications: in control of edema when diuresis is required, in congestive heart failure, the premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs certain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb anwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents. Contraindications: none, except in complete renal shutdown.

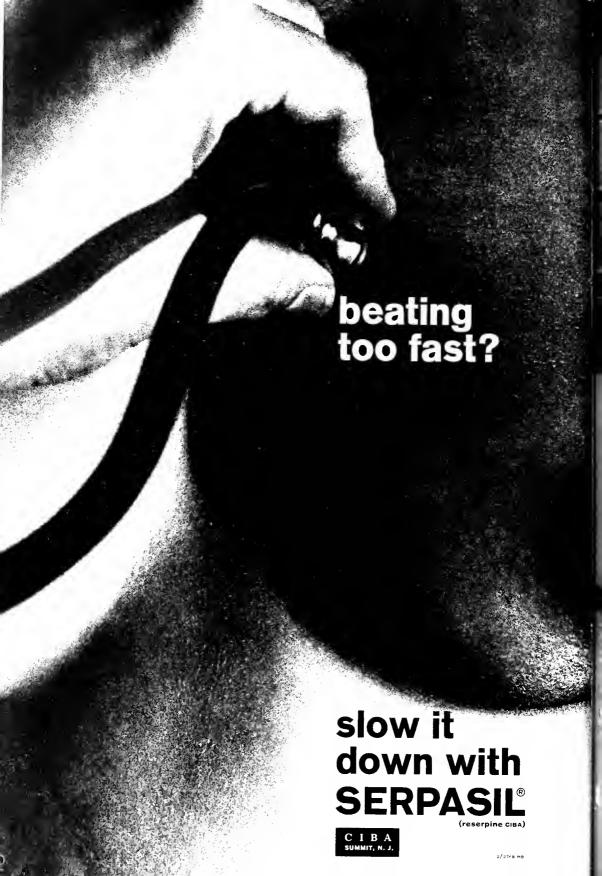
Precautions: when Naturetin is added to an antihypertensive regimen including hydralazine, eratrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all reparations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous rop in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin egimen . . . in hypochloremic alkalosis with or without hypokalemia . . in cirrhotic patients or those on ligitalis therapy when reductions in serum potassium are noted . . . in diabetic patients or those predisposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs—eg or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

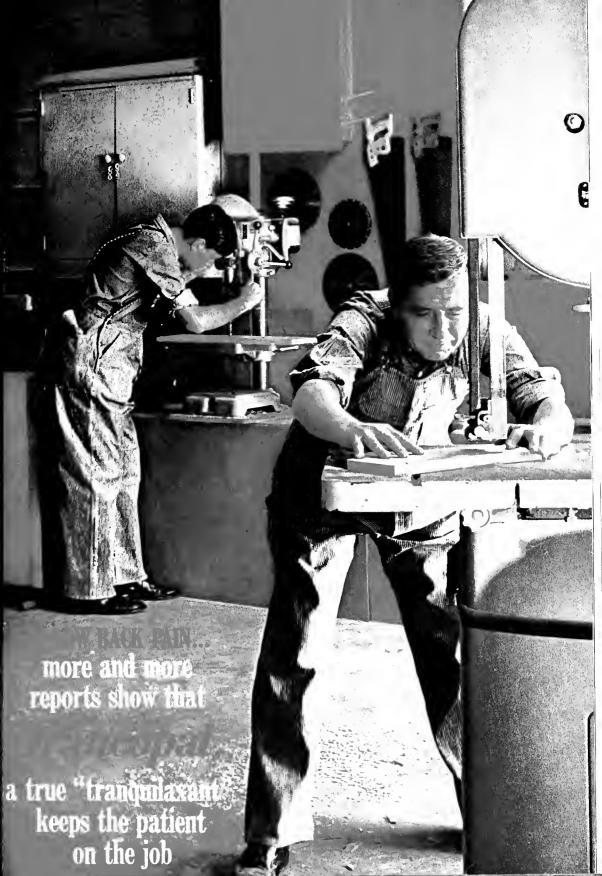
laturētin – Dosage: in edema, average dose, 5 mg., once daily, preferably in the norning; to initiate therapy, up to 20 mg., once daily or in divided doses; for maintenance, 2.5 to 5.0 mg., daily in a single dose. In hypertension: suggested nitial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending on the individual response of the patient. When Naturetin is added to an antihypertensive regimen with other agents, lower maintenance doses of each trug should be used.

Naturetin - Supplied: tablets of 2.5 mg. and 5 mg. (scored).

Squibb Quality— Sid-morning

RANDIXIN'® AND "NATURETIN" ARE SQUIBB TRADEMARKS





relieves painful muscle spasm and relaxes the patient



Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman, Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: 66 Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks. 992

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

fullin and Epifano call Trancopal 66...a very effective skeletal muscle spasmolytic. 993 hey found that Trancopal brought good to excellent relief to all of 39 patients with keletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and itervertebral disc syndrome. (No side effects were noted except that one patient had slight ryness of the mouth.)

'he pattern is similar in every new series reported: Ganz, DeNyse, Shanaphy and Stough.

Trancopal is a true "tranquilaxant"

rancopal "...combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that 66... the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable. 95° Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety and tension states. As Ganz says, 66... a most valuable drug for relieving tension, apprehension and various psychogenic states... allows the patient to use his energies in a more productive manner in overcoming his basic problems." ⁴

Trancopal

a true "tranquilaxant"

that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects, and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders

Psychogenic disorders

Low back pain (lumbago) Neck pain (torticollis) Bursitis

Rheumatoid arthritis Osteoarthritis Disc syndrome Fibrositis
Ankle sprain,
tennis elbow
Myositis

Postoperative muscle spasm Anxiety and tension states Dysmenorrhea Premenstrual tension

Asthma Angina pectoris

Alcoholism

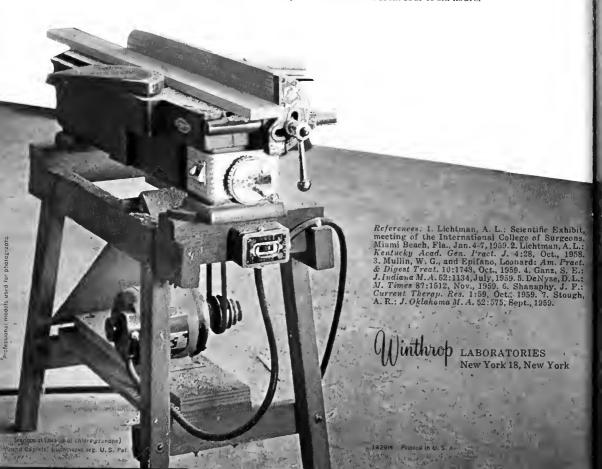
Now available in two strengths:

Trancopal Caplets®, 100 mg. (peach colored, scored), bottles of 100.

STRENGTH

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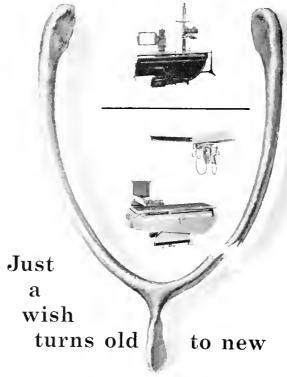
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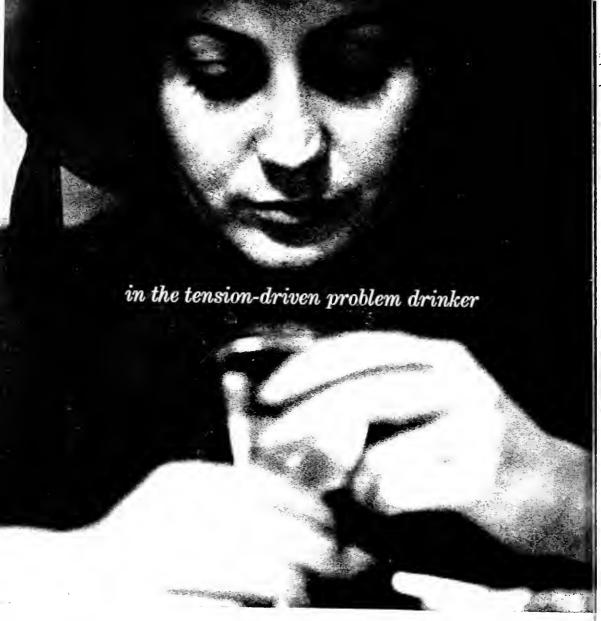
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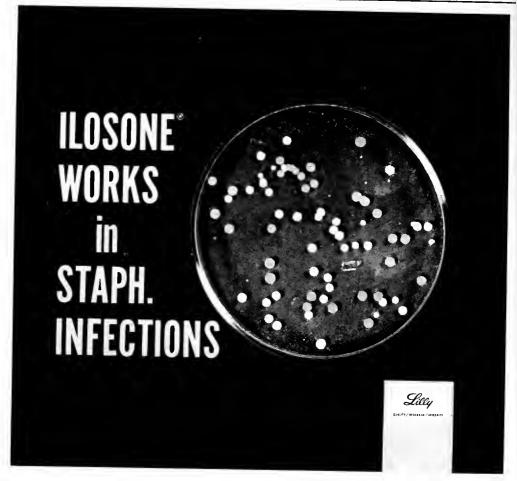


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Roentgen Changes in Salmonella Osteomyelitis Occurring in Children With and Without Sickle Cell Anemia

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CHAPEL HILL

Involvement of the skeletal system is an unusual but well recognized complication of salmonellosis. Recent clinical reports suggest that patients with sickle cell anemia are predisposed to the development of osteomyelitis caused by a variety of bacteria, and by the Salmonella genus in particular. Certain radiologic changes in patients with osteomyelitis complicating sickle cell anemia have been described as unique. It is the purpose of this paper to describe 3 patients with Salmonella osteomyelitis treated recently at the North Carolina Memorial Hospital and to attempt to evaluate in each of these the worth of radiologic changes in diagnosis.

Incidence and Pathology

The Salmonella group comprises a variety of paratyphoid organisms-more than 150 species-which ordinarily are intestinal parasites. Bacteremia occurring in salmonellosis is, however, quite common and has become a principal means of diagnosis. The blood-borne infection may result in the development of a septic process in any organ. Paratyphoid osteomyelitis is somewhat less frequent than bone infection following typhoid fever, but once established, may be the more virulent(1). Osteomyelitis subsequently develops in approximately 1 per cent of patients having typhoid fever (2), while skeletal involvement occurs in only 0.2 per cent of the cases of paratyphoid fever(3). In a breakdown by age groups, however, of 1,497 cases of Salmonella infections at the New York Salmonella Center, Seligman⁽⁴⁾ found that 17 per cent were in infants and 40 per cent were in children under 10 years of age. Osteomyelitis and arthritis were found in 20 per cent of the children under 2 years of age when Sal. choleraesuis was the offending organism.

The skeletal lesions of paratyphoid infections may exhibit pathologic features which distinguish them from the more frequently occurring staphylococcal and streptococcal lesions, and even from those associated typhoid infection. The lesions are multiple in many instances. Involvement of the bones of the shoulder girdle, ribs, spine, and long bones, particularly of the upper extremities, has been reported most frequently. Inflammation usually begins beneath the periosteum in the diaphyseal portion of the bone rather than in the metaphysis. The earliest change is thickening and elevation of the periosteum of the shaft, resulting from periostitis. If the lesion remains localized, nonsuppurative and sclerosing osteitis of the adjacent bone may occur. The process is more likely to spread throughout the bone, and once diffuse suppuration has developed, there is no reliable way of pathologically distinguishing Salmonella osteomyelitis from changes resulting from staphylococcal or streptococcal infections. Bacterial invasion of the joint may also involve the bone. Suppurative arthritis ordinarily precedes osteomyelitis in these instances, with destruction of synovial membrane, cartilage, and eventually bone. The infections are usually monarticular, and large joints are more often affected.

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Sickle cell anemia is a familial chronic hemolytic disease characterized by the generation of abnormal hemoglobin with resultant sickle-shaped erythrocytes under certain conditions. The abnormal erythrocytes are destroyed prematurely by the reticuloendothelial cells, and compensatory hyperplasia of the blood-forming organ occurs. The result in the skeleton, early in life, is overgrowth of marrow, causing dilatation of the medullary cavity and atrophy of the spongiosa and corticalis from pressure. Infarction of the bones is common, particularly in children.

Bone infections, generally, are more common in patients with sickle cell anemia than in normal individuals. During the last 10 years several cases of Salmonella osteomyelitis complicating sickle cell anemia have been reported in the literature (Burch. Wigh and Thompson. Hughes and Carroll. 1957, and Lohmuller and Marshall. In all, approximately a dozen instances of concurrence of the diseases have been recorded.

Roentgenologic Investigation

The roentgenographic changes occurring in one case of osteomyelitis complicating sickle cell anemia were well described in detail by Wigh and Thompson⁽⁷⁾. They noted that the diaphyses rather than the juxta-epiphyseal regions were infected initially, in accord with the observations of others (Burch), MacDonald, Veal, and Veal and McFetridge).

A distinctive feature pointed out by Wigh and Thompson⁽⁷⁾ was the presence of linear intracortical fissuring paralleling the shaft adjacent to the medullary involvement. The length of the fissuring was the same as the extent of the medullary disease. There were short intraosseous sinus tracts between the obvious medullary in-



Fig. 1. Salmonella osteomyelitis complicating sickle cell anemia. Bone destruction is present throughout the entire shaft of the left radius. A well developed involucrum is present, indicating late stages of bony involvement with the rebuilding process well established. A pathologic fracture is shown in the distal radius (Same case as Fig. 2.)

fection and the cortical fissure. The fissuring was clearly defined as lying between cortex and endosteal limits; it did not represent uncalcified matrix between new subperiosteal bone and cortex.

Other frequently observed roentgen findings are: (1) multiple bone involvement, (2) irregular areas of destruction, (3) extensive periosteal proliferation, (4) involucrum formation, and occasionally, (5) pathologic fractures.

Material

The material available for study consists of 3 patients with Salmonella osteomyelitis verified by bacteriologic culture from the diseased tissues. All of the patients were children below the age of 15 years. Two patients (cases 1 and 2) had clinical manifestations of sickle cell anemia, and the diagnosis was confirmed by electrophoresis. Both patients had hemoglobin type "S", specific for the anemia and not the trait. In these patients the osteomyelitis developed in the long bones of the upper extremities, providing adequate opportunity to observe osseous and particularly cortical changes. One of these 2 patients also





Fig. 2. A film of the right forearm (A) shows extensive cortical involvement of the diaphysis of a long bone (radius). There is early cortical fissuring in the distal right humerus (arrow). A small draining sinus (arrow) is seen to perforate the periosteum of the radius. (Same case as Fig. 1.) A film made two months later (B) reveals almost complete healing...

had vertebral disease. In the third patient, who did not have sickle cell anemia (normal hemoglobin type "A"), skeletal infection developed first in the knee joint as a suppurative arthritis, and osteomyelitis of the adjacent tibia was secondary to the joint disease.

Case 1 (figs. 1 and 2)

A 4 year old Negro girl was admitted to the North Carolina Memorial Hospital because of fever, pain, and swelling in both elbows of 17 days' duration. She had anemia with 6 Gm. of hemoglobin and a hematocrit value of 20. A sickle cell preparation was positive and electrophoretic studies showed hemoglobin type "S". Sal. bareilly was cultured from the elbow-joint aspirate. Radiologic examination revealed alteration of bony density and architecture suggestive of osteomyelitis of the right humerus, both radiuses, and both ulnas. Other bones were normal.

A lateral radiograph of the left forearm (fig. 1) shows destruction throughout the entire shaft of the left radius. A pathologic fracture is noted in the distal radius. The partially destroyed shaft is seen to be encased in a well developed involucrum, indicating late stages of bony involvement, with the rebuilding process well established.

A film of the right forearm (fig. 2A) shows similar changes, somewhat less marked, and illustrates well the extensive cortical involvement of the diaphysis of a long bone. There is evidence of beginning cortical fissuring in the distal right humerus. A small draining sinus in the proximal radius is seen to perforate the periosteum. A film made two months later (fig. 2B) revealed a considerable degree of healing.

Case 2 (figs. 3 and 4)

A 14 year old Negro boy was admitted to the pediatric service because of fever, multiple joint pains, and exercise intolerance. The patient had icteric conjunctivae and soft tissue swelling of the left elbow, with marked tenderness and limitation of motion. Anemia was present, with a hemoglobin of 8.2 Gm. and a hematocrit of 24. Electrophoretic studies revealed type "S" hemoglobin. A heavy growth of S. choleraesuis was cultured from the venous blood and left elbow joint aspirate. Initial radiologic examination revealed a destructive process involving the left forearm and changes of hematopoietic disease in the spine, but no evidence of collapse or infection.

A film of the left forearm (fig. 3) revealed multifocal destructive areas in the upper portion of the shaft of the radius and ulna. Marked proliferative periosteal reaction is present and cortical fissuring is a prominent finding.



Fig. 3. Salmonella osteomyelitis complicating sickle cell anemia. The left elbow exhibits multifocal destructive areas in the upper portion of the shaft of the radius and ulna. Marked proliferative periosteal reaction is present and cortical fissuring (arrow) is a prominent finding. (Same case as Fig. 4.)

Films of the thoracolumbar spine (fig. 4A) made eight weeks after admission revealed the development of a destructive process involving the thoracic 12, lumbar 1 and lumbar 2 vertebrae. Earlier films showed the classic ballooning of the disc spaces, with a generalized decrease in density of the centra prior to the vertebral collapse. Films made three weeks later after recovery (fig. 4B) show bony sclerosis and healing without evidence of progression of the destructive process. No bacteriologic studies were made from this region.

Case 3 (fig. 5).

A 6 month old Negro female infant was admitted to the pediatric service because of a painful, tender, swollen right knee. During hospitalization Sal. choleraesuis was cultured from turbid fluid removed from the right knee joint. There was only a mild nutritional anemia and several sickle cell preparations revealed no abnormal ery-

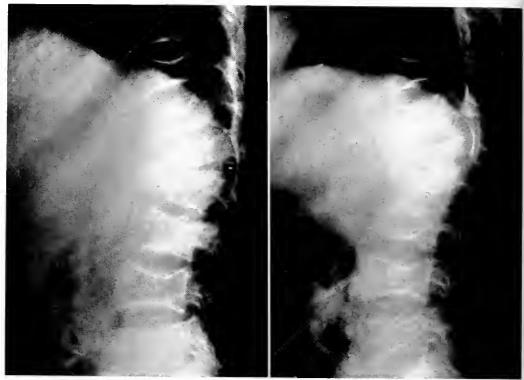


Fig. 4. The thoracolumbar spine shows a marked destructive involving T-12, L-1 and L-2 with vertebral collapse (Λ). There is narrowing of the intervening disc spaces characteristic of an infectious process. Λ film made three weeks later (B) shows bony sclerosis and disc space bridging indicating healing without further evidence of destruction. (Same case as Fig. 3.)

throcytes. Electrophoretic studies showed a normal hemoglobin, type A. There was no history of blood transfusions. The child did not appear ill at any time.

Films of the right knee (fig. 5) showed softtissue swelling, joint effusion and scattered areas of subchondral bone destruction in the proximal epiphyseal center of the tibia. There is subepiphyseal lysis of bone in the proximal end of the tibia, with minimal evidence of periosteal new bone. A moderate-sized radiolucent defect is noted in the anteromedial aspect of the tibial metaphysis.

Comment

We have taken this opportunity to study and compare 3 cases of Salmonella osteomyelitis, 2 of which were complications of sickle cell anemia. This summary is presented as further support of previous observations by Hodges⁽¹⁰⁾, Hughs and Carroll⁽⁸⁾, and Lohmuller and Marshall⁽⁹⁾ that Salmonella osteomyelitis complicating sickle cell anemia probably is more than coincidental.

The predisposition of the infectious process to involve predominantly the diaphysis rather than the metaphysis, and intracortical fissuring parallel to the long axis of the involved bone are illustrated, and may well be valid as specific diagnostic aids in roentgen examinations done fairly early in the disease.

Only a limited number of cases throughout the literature have been available for review, but specific and similar findings are being described constantly. A striking difference is seen between the bone changes in our 2 patients with both diseases and those in the child who had Salmonella osteomyelitis in the absence of sickle cell anemia.

Some disagreement has arisen regarding the opinions expressed by Rowe and Haggard⁽¹¹⁾, who reported 2 cases of bone changes in children with sickle cell anemia. *Sal. typhimurium* was cultured from an ab-



Fig. 5. Salmonella arthritis and secondary osteomyelitis, Radiographs of the right knee (A & B) show joint effusion and scattered areas of subchondral bone destruction in the proximal epiphyseal center of the tibia. There is subepiphyseal lysis of bone in the proximal end of the tibial metaphysis with minimal evidence of periosteal new bone.

scess on the hand in 1 case. The authors believed that the abnormal bone picture was not related to the Salmonella organism but due rather to infarction alone. While bone infarction may be a predominant factor in producing pathologic bone changes in uncomplicated sickle cell anemia, other investigators do not share the view that the extensive changes accompanying salmonellosis can be explained other than by the presence of septic bone disease. This is also our belief, since in 2 of the cases presented

in this paper salmonellal osteomyelitis complicating sickle cell anemia was definitely established and the unique bone changes which have been described by others in this combination of diseases are validated.

Summary

Three cases of Salmonella osteomyelitis occurring in Negro children are reported. Sickle cell anemia was proved to be present in 2 of the cases. The skeletal changes occurring in these cases give further support

to the opinion that children with sickle cell anemia have a predisposition to osteomyelitis and that there is a striking tendency for paratyphoid organisms to be the offending agents. The roentgen characteristics of polyostotic involvement, particularly of the upper extremities, diaphyseal predilection, extensive periosteal proliferation, and longitudinal fissuring of the cortex of tubular bones are further substantiated.

References

- Veal, J. R.: Typboid and Paratyphoid Osteomyelitis, Am. J. Surg. 43:549-597 (Feb.) 1939.
- Murphy, J. B.: Bone and Joint Disease in Relation to Typhoid Fever, Surg., Gynec. & Obst. 23:119-143 (Aug.) 1916.
- Webb-Johnson, A. E.: Surgical Complications of Typhoid and Paratyphoid Fevers, Lancet 2:813-820, 1917.

- Seligmann, E., Saphara, I., and Wasserman, M.: Salmonella Infections in the U.S.A.; A Second Series of 2,000 Human Infections Recorded by the N. Y. Salmonella Center, J. Immunol. 54:69-87 (Sept.) 1946.
- Diggs, L. W., Pulliam, H. N., and King, J. C.: Bone Cbanges in Sickle-cell Anemia, South, Med. J. 30:249-258 (March) 1937.
- Burch, J. E.: Paratyphoid Osteomyelitis: A Case Report, South. M. J. 42:138-139 (Jan.) 1949.
- Wigh, R., and Thompson, H. J.: Cortical Fissuring in Osteomyelitis Complicating Sickle-cell Anemia, Radiology 55:553-556 (Oct.) 1950.
- Hughs, J. G., and Carroll, D. S.: Salmonella Osteomyelitis Complicating Sickle-cell Disease, Pediatrics 19:184-191 (Feb.) 1957.
- Lobmuller, H. W., and Marshall, J. F.: Hemoglobin C-S Disease Complicated by Paracolon Osteomyelitis, A.M.A. Arch. Int. Med. 101:761-764, 1958.
- Hodges, F. J., Holt, J. F., Jacox, H. W., and Collins, V. P.: The 1951 Year Book of Radiology, Chicago, Year Book Publishers, 1951, p. 88.
- Rowe, C. W., and Haggard, M. E.: Bone Infarcts in Sickle-cell Anemia, Radiology 68:661-668 (May) 1957.

The Cornell Medical Index Health Questionnaire as a Diagnostic Aid

ROBERT R. HUNTLEY, M.D.

CHAPEL HILL

The absolute necessity of a complete clinical history in the adequate evaluation of patients is well recognized. However, this part of the work-up is quite time consuming and any procedure which would shorten the time required without reducing the quality of the history would be a useful adjunct to patient care. The use of the Cornell Medical Index Health Questionnaire in ambulatory patient care has been well described by Brodman and others(1) and Erdmann(2). The present study was undertaken to discover if this questionnaire would be of value in improving the completeness of clinical histories as obtained in a teaching hospital out-patient department.

Procedure

During the summer of 1959 a copy of the Cornell Medical Index-Medical Questionnaire (CMI) and an explanatory letter were mailed to 92 consecutive patients who had been given their first appointments for complete medical evaluation in the General

From the Departments of Medicine and Preventive Medicine, University of North Carolina School of Medicine, Chapel Hill Clinic of the North Carolina Memorial Hospital. The accompanying letter explained the purpose of the form and requested that it be returned at the time of the clinic visit. Twenty-two of these patients cancelled or failed to come in for their appointments. Thus 70 patients (76 per cent) who were mailed CMI's came in for diagnostic workup. Of this number, 56 patients (80 per cent) returned with the forms completed, which means that 60 per cent of the original 92 CMI'S were recovered for study.

When the form was received by the clinic secretary it was delivered directly to the author, so that it was not used in the clinical evaluation of the patient. Each form was then studied and tentative clinical impressions were recorded. These impressions were usually coded as tentative diagnoses, but in some instances they were coded simply as "systems requiring careful study." The CMI's were further examined for evidence of emotional disturbance on the basis of the total number of positive answers, as well as the positive answers to certain specific questions designed to bring out evidence of psychopathologic disorders.

After this portion of the study was completed, and some weeks after these patients were first seen, their clinical records were examined from the standpoint of diagnoses made, pertinent points in the history indicated on the CMI but not mentioned on the clinical work-up, diagnoses made clinically which were not suggested by the CMI, and, finally, the emotional evaluation of the patient from the CMI as compared with that made by the examining physician and recorded on the clinical record.

Results

As a result of this comparison, it was determined that in 51 patients (90 per cent) the primary diagnosis was correctly indicated by the CMI, at least by system. In 5 (10 per cent) the diagnosis was missed by the CMI. The five diagnoses missed included functional heart murmur, glaucoma, anxiety reaction, cardiac neurosis, and nontoxic, benign thyroid nodule (table 1).

The CMI correctly indicated the system in which the secondary diagnosis occurred in 29 of the 35 secondary diagnoses made. Twenty-one charts contained no secondary diagnosis. Thus in 83 per cent of the secondary diagnoses the correct system was indicated by the CMI. Secondary diagnoses which were not indicated included mental deficiency (2 cases), benign prostatic hyperplasia, hypertensive cardiovascular disease with congestive heart failure (in a patient with carcinoma of the lung), and neurologic deficit of the left leg of unknown etiology.

On 13 charts a third diagnosis was recorded and in all 13 instances this diagnosis had been indicated by the CMI. The majority were such diseases as varicose veins, benign prostatic hyperplasia, and obesity.

In 21 of the 56 clinical records (38 per cent), a significant emotional element in the patients' problems was noted. In 2 of these, this element was not detected by the CMI. On rereading these two CMI's, however, it was apparent that one of the patients presented evidence of hysterical symptomatology by volunteering a considerable amount of information which was not requested, and by having a large total of positive answers. The fact that a number of these positive answers concerned the cardiovascular system led to the erroneous

Table I

2 44.0-0				
Use of the Cornell Medical Index-Questionnaire With 92 Consecutive Patients				
Total CMI's mailed	92			
No. patients keeping appointment for work-up	70			
No. of CMI's returned	56 (80%)			
Detection of primary diagnosis by CMI	90%			
Detection of secondary diagnosis* by CMI	83%			
Detection of third diagnosis* by CMI	100%			
Possible "Missed diagnosis" detected by CMI	15 (26%)			
Emotional problems recognized on clinical evaluation	38%			
Emotional problems indicated by CMI's	70%			
*Applicable where a secondary or t was present.	hird diagnosis			

impression (from the CMI) that she had heart disease, whereas the clinical diagnosis was cardiac neurosis.

According to the CMI, 38 of the 56 patients had significant emotional problems (70 per cent as compared with 38 per cent from the clinical studies). Most of these patients gave positive answers to such questions as, "Do you get nervous and shaky when approached by a superior?"; "Do you usually feel unhappy and depressed?"; "Do you often cry?"; "Do you often wish you were dead and away from it all?"; "Are you always in poor health?"; "Are you always ill and unhappy?", and others in this vein. It is suspected that these patients have emotional problems which were overlooked during their clinical examinations. This is not to say that the emotional problem represented the primary diagnosis, because in the majority of cases it most likely did not. In order to understand a patient's illness, however, these factors are of obvious importance.

In this group of 56 cases, a total of 15 (26 per cent) organic diagnoses, all of at least potential importance to the patients, were suggested by the CMI's but not noted on the clinical history. These included hemorrhoids in 2 patients: arthritis and varicose veins in 1; varicose veins in 1; epilepsy in 2; deafness in 1; alcoholic intake and a history of jaundice in 1; a history of probable syphilis in 1 (later confirmed by a positive VDRL); a draining ear with decreased hearing in 1; a history of worms with a clinical finding of 7 per cent eosinophilia and no stool studies in 1; vaginal discharge in 1, with no pelvic examination recorded; a history of rheumatic fever in 1 patient, who was found on examination to have a mitral systolic murmur believed by the examiner to be functional; bladder symptoms in 1 patient with pyuria on urinalysis, which was not further treated or evaluated; nasal allergy in 1; and symptoms strongly suggestive of peptic ulcer in 1 patient on whom review of systems was recorded as "GI negative."

Comment

Those who have worked most intensively with the Cornell Medical Index-Health Questionnaire are impressed with its value as an adjunct to comprehensive evaluation of patients. It is easily administered and can usually be completed in less than 30 minutes by a patient who has had an elementary education. Other patients may require help, which can frequently be given by a relative. In the present study all except one of the CMI forms submitted were properly completed, and in that one the questions that were answered correlated well with the clinical history.

This study tends to confirm the impression that the CMI serves to give a more comprehensive review of systems, as well as to provide insight into the emotional and personal problems of patients which otherwise is difficult to obtain. This is particularly true in the evaluation of new patients. Thus it would seem that this instrument should be widely applicable in office and and clinic practice. It should also be useful

in obtaining more complete medical records in community hospitals. The fact that this type of medical information is easily obtained and quickly evaluated by the physician should result in better patient care where it is used to complement a carefully taken clinical history.

Summary

The results of a comparative study of tentative diagnoses made by means of an evaluation of Cornell Medical Index-Health Questionnaires and clinical evaluations made independently have shown that the CMI indicates the area of the patient's major medical problems in the majority of instances, and points out minor medical and emotional problems which might otherwise be overlooked. It would therefore appear to have wide usefulness in medical practice.

References

- Erdmann, A. J., Jr., Brodman, K., Lorge, I., and Wolff H. G.: The Cornell Medical Index-Health Questionnaire V. The Outpatient Admitting Department of a General Hospital, J.A.M.A. 149:550-551 (June 7) 1952.
- Erdmann, A. J., Jr.: Experiences in the Use of a Self-Administered Health Questionnaire, A.M.A. Arch. Industrial Health 19:339-344 (March) 1959.
- Brodman, K., Erdmann, A. J., Jr., Lorge, I., and Wolff, H. G.: The Cornell Medical Index: An Adjunct to Medical Interview, J.A.M.A. 140:530-534 (June 11) 1949.
- Brodman, K., Erdmann, A. J., Jr., Lorge, I., Gershenson, C., and Wolff, H. G.: The Cornell Medical Index-Health Questionnaire III. The Evaluation of Emotional Disturbances in a General Hospital, J. Clin. Psychol. 8:289-293 (July) 1952.
- 5. Reader, G.: Personal communication, 1959.

The depressive episodes may vary greatly in intensity. The mildest varieties may be unrecognized clinically and may appear only as periods of inertia or "staleness." The patient may complain merely of fatigability and a lack of ambition with an unexplained difficulty in concentrating his attention on tasks at hand. He may worry about matters that previously he had been able to resolve without difficulty. His family may relate that he has become stubborn, peevish and fault-finding. Physically he may complain of anorexia, loss of weight and disturbed sleep. The most typical variety of insomnia is that of early morning awakening and sleeplessness for the two or three hours before the accustomed time of arising. The patient usually believes that his disorder is of organic origin and that his downheartedness is the natural result of his ill health. Too often such patients are subjected to well-meaning but useless "treatment" with vitamins, hematinics and a variety of sex hormones. Barry, M.J., Jr., and Faucett, R. L.: The Depressed Patient, Proc. Staff Meet., Mayo Clin. 34:88 (Feb. 18) 1959.

The Tissue Committee In A General Hospital

LEDYARD DECAMP, M.D.

CHARLOTTE

In the summer of 1952, following recommendations of our pathologist, a Tissue Committee was appointed by the executive committee of the staff of Presbyterian Hospital in Charlotte. The primary reason for this action was (1) to encourage staff members to maintain more complete and detailed records of surgical patients, and (2) to comply with recommendations of the Joint Commission on Accreditation of Hospitals.

The Tissue Committee has usually consisted of the following: a member of the Department of Internal Medicine as chairman; a general surgeon or urologist; an obstetrician and gynecologist; a pathologist, and a radiologist. In the first two years of its existence the Committee met twice a month, but in the last four and a half years it has not had to meet more than once a month, as the number of charts to be reviewed has steadily dropped.

The hospital charts selected for review were those in which some discrepancy between preoperative and postoperative diagnoses, a discrepancy between the clinical and pathologic diagnoses, or both were noted by the chief of the Department of Pathology. Over the six and a half years span of this survey, between 80 and 85 per cent of all the charts studied were found to be satisfactory on close scrutiny (table 1). A number of records studied were considered to be incomplete in certain respects, and were referred to the Record Committee for completion. This number averaged 18 per cent in the first two years, falling to approximately 11 per cent in the last three years of this study.

A final group were those charts in which the clinical and pathologic diagnoses were at wide variance or indications for surgery were felt to be inadequate following the submission of additional data by the attending physician. In the first two years of the survey this category averaged 25 per cent of all charts reviewed and dropped to a little more than 7 per cent in the last three years of our study.

From Presbyterian Hospital, Charlotte, North Carolina.

Table 1
Experience of Tissue Committee

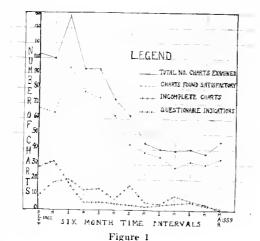
Av Eac	h Six First Two Years			Last Three
Charts reviewed	84	21		
Charts found satisfactory Incomplete charts	72 15	$\frac{33}{4.6}$	85.7 18	80 11
Charts showing questionable indica tions for surgery	a- 21	3	25	7.3

Every referred chart in the latter category was accompanied by a brief note expressing the Committee's views and requesting additional information which might have any direct bearing on the case. This step frequently led to the submission of additional history, summaries of office treatments, and so forth, which placed an entirely different light on the procedure performed and justified re-classifying the record as satisfactory.

The Tissue Committee has functioned in an advisory capacity entirely, and reports its findings to the executive committee of the staff. It was originally intended that any disciplinary measures would be taken by the executive committee. In the six and a half years of operation no member of the staff has had to be disciplined for repeated ill advised or unnecessary surgery.

In its first years of operation an occasional staff member took issue with the Tissue Committee's comments or recommendations. A year of membership on the Committee gave these physicians a clearer insight into the problems of evaluating the managment of a controversial case, and helped to show that the value of a record depends upon what is recorded in it, rather than on office notes.

Figure 1 graphically summarizes the results of the Tissue Committee's experience over the period from August, 1952, to March, 1959. It might be worth mentioning that in the last year of this survey there was an increase in bed capacity from 280 to 402 and almost a 40 per cent increase in the amount of surgery done. In



spite of this increase, the number of incomplete records or unjustified operations has dropped to almost zero.

Conclusions

It is believed that the two most important contributions that can be made by a conscientiously functioning Tissue Committee in a non-teaching general hospital are the following;

- The improvement of perfunctory and incomplete records by filling in additional details of the patient's illness and past medical history that have a direct or an indirect bearing on the operation performed.
- 2. The reduction of the number of ill advised or hasty operations performed on the basis of perfunctory or inadequate preoperative studies by requiring staff surgeons to give reasonable justification for whatever procedure is done on each hospital record.

Discussion

Dr. C. T. Daniel (Fayetteville): This is a timely subject, for I feel that much can be done to im-

prove the tissue committee in many of our hospitals. I wholeheartly agree on the conclusions reached by the author; namely, that improved records lead toward improved practice, with fewer instances of unwarranted or ill-advised surgery.

The reaction to a tissue committee is quite variable. It is assumed that the majority of doctors are competent and strive to give the best possible care to a patient. It is also evident that most doctors tend to resent any form of restrictive supervision of their activities. The tissue committee must strive to avoid personality clashes and conduct itself in such a manner that its purpose can be accomplished without causing ill will.

I would like to mention a few points that I feel contribute to the efficiency of our tissue committee. Rather than have the pathologist screen our charts for discrepancies, we utilize the clinicians on the committee who are better suited to evaluate a case as a whole. There are many cases in which the clinical and pathologic diagnoses agree, but the procedure performed is questionable.

The function of the tissue committee as an educational tool is stressed. Well managed cases of general interest are often presented during a session. At the present time we are trying a plan that is aimed at leaving the name of the operator out of the discussion if he desires. When a chart is to be presented, the physician is notified and given an opportunity to discuss the case with the committee prior to the staff meeting. The case is then presented by a qualified member of the committee, utilizing the material available in the record and supported by data from the recent literature in his discussion.

One of the objections voiced by critics of the committee has been that cases brought up for discussion usually resolve into discussion of gynecologic procedures.

In reviewing our records for the past year, I found that 72 per cent of the tissues studied were from gynecologic patients. Approximately half of these patients were operated on by doctors other than gynecologists. It was encouraging to note that the uterine suspensions, bilateral salpingectomies, exploratory laparotomies, and therapeutic abortions had been reduced to a minimum. I have little doubt that a tissue committee made up of qualified, conscientious members can do a great deal toward raising our surgical standards.

No prescription should ever leave the physician's hands unless it is dated and explicit directions regarding dosage, method of administration and refills are given. The term "as directed" should never be used. These simple steps are essential if the physician is to protect his patient properly.—Friend, D. G.: Polypharmacy—Multiple-Ingredient and Shotgun Prescriptions, New England J. Med. 260:1017 (May 14) 1959.

Non-Hormonal Adrenal Cortical Carcinoma

A Case Report

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and
W. RALPH DEATON, JR., M.D.

GREENSBORO

Primary tumors of the adrenal cortex are quite rare, and adrenal cortical carcinomas, which are non-hormonal and as such produce no evidence of glandular effect, are the rarest of all. (Cahill and Melicow's (1) classification is helpful in placing such tumors in perspective with other tumors of the adrenal gland.) Unfortunately, the nonhormonal tumors are also among the most malignant of all tumors, and in the majority of the reported cases the diagnosis has been made only after metastases have developed. Wood and others(2), in a survey of the European and American literature from 1923 to 1957, were able to find reports of only 27 cases wherein the diagnosis had been made before metastases occurred. The metastases have typically invaded the soft tissues-namely, the retroperitoneal lymph nodes, the liver, and the lungs, usually in that order. Death usually ensues within a year after metastasis occurs or is discovered. Heinbecker and others(3) out of 10 cases of cortical carcinoma could report only one patient alive, and this only 10 months after the operation. Their longest period of survival was three years.

The case described in this report differs from those which have been reported previously in two respects; (1), the longevity of the patient after the disease was discovered, and (2) the pattern of the metastases.

Case Report

The patient, a white man, was first seen at the age of 41 because of a urinary tract infection. Examination at that time revealed a movable mass approximately the size and shape of a large orange, and visible on x-ray examination of the abdomen, under the left subcostal margin; the patient had been previously unaware of the mass. He was treated successfully for the urinary infection, but refused laparotomy for removal of the mass.

From the Medical and Surgical Services of the Moses H. Cone Memorial Hospital, Greensboro, North Carolina.

He was seen three years later by another physician for right ureteral calculus. The record contains no mention of the mass in the left upper quadrant. Albumin and red blood cells were present in the urine. An intravenous pyelogram revealed hydronephrosis on the right, but no abnormality in the region of the left kidney was seen on the x-ray films. The blood calcium was 9.4 mg. per 100 cc., and the phosphorus was 2.4 mg. per 100 cc.

His next examination was a year later, when he complained of headache, vomiting, and pain in the left lower quadrant of the abdomen. On this occasion the mass in the left upper quadrant was again identified. Blood pressure was 110 systolic, 80 diastolic. Six months later, or four and a half years after the mass was first discovered, the patient, now 45 years old, complained of episodes of fainting, and a weight loss of 20 pounds. He had been working in a steel mill at hard physical labor, and except for the illnesses described above had been well. A nontender firm, grapefruit-sized mass (roughly 15 cm. in diameter) which moved with respiration was present in the left upper quadrant. Blood pressure was 140 systolic, 90 diastolic. Laboratory studies revealed microscopic hematuria, a flat glucose tolerance curve, an eosinophil count of 176 per cubic millimeter, a negative spinal puncture, normal hemogram, sedimentation rate of 8 millimeters per hour, and a normal intravenous pyelogram. The bariumfilled stomach was seen to be displaced cephalad and medially by the mass when the patient was in the prone position.

On exploratory laparotomy a spherical solid tumor was found attached to the lower pole of the left adrenal gland. The entire gland and tumor were removed together. The pathologic report (H. L. Lennon, M.D.) stated that the specimen was a smooth rounded encapsulated mass, 11.5 cm. in diameter. On cut section (fig. 1), the periphery was described as soft and yellow,

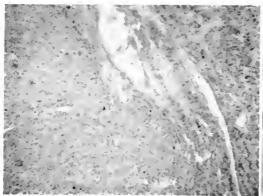


Fig. 1. Low power photomicrograph showing the demarcation between the cortical adenoma (upper right) and the degenerating malignant tissue (lower left).

with a central gray area, 7 cm. in diameter, which showed evidence of hemorrhagic degeneration. Another degenerative gray area. 3.5 cm. in diameter, was present near one edge of the mass. Both grossly and microscopically the yellow tissue was consistent with typical adrenal cortical adenoma (fig. 2). On examination of tissue degenerative areas, the cells, although of adrenal origin, were large and irregular in shape, staining characteristics, and arrangement (fig. 3). The line of demarcation between the gray and yellow tissue was sharp for the most part, with a narrow fibrous band between: however, areas suggestive of invasion of the adenoma by the larger irregular cells were seen. The pathologic diagnosis was adrenal cortical adenoma with carcinomatous degeneration.

The patient was given small quantities of steroids postoperatively, because the functional status of the opposite adrenal gland was unknown. The dosage was rapidly reduced and then terminated on the fifth day. On the seventh postoperative day disruption of the wound occurred and secondary closure was necessary. The patient recovered and returned to hard physical labor.

Two years later he began to complain of low back pain, but physical examination and roentgenograms of the spine revealed no abnormality. Four months afterwards, when the back pain had become more intense, x-ray examination revealed sclerotic



Fig. 2. High power photomicrograph of adenomatous portion of tumor shown in figure 1. Note the regularity of arrangment and a tendency to form glands,

changes in the fourth lumbar vertebra, with proliferative spurring at the bone margins (fig. 4). The joint spaces were well preserved. The cause of this lesion was unknown, but metastatic carcinoma was considered. The knee jerk was now absent on the right and there was sensory loss involving the fourth lumbar dermatome on the right. A myelogram showed encroachment on the spinal canal in the region of the third to the fifth lumbar vertebrae. Microscopic hematuria was again present; the hemoglobin was 14.5 Gm., the white blood cell count 17,000 with 80 per cent polymorphonuclears, calcium was 9.4 mg. per 100 cc., phosphorus was 2.4 mg. per 100 cc., alkaline phosphatase was 1.8 Bodansky units, and acid phosphatase was 1.3 Bodan-

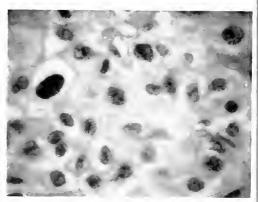


Fig. 3. High power photomicrograph of malignant tissue shown in figure 1. Note irregularity of shape, staining characteristics, and arrangement.

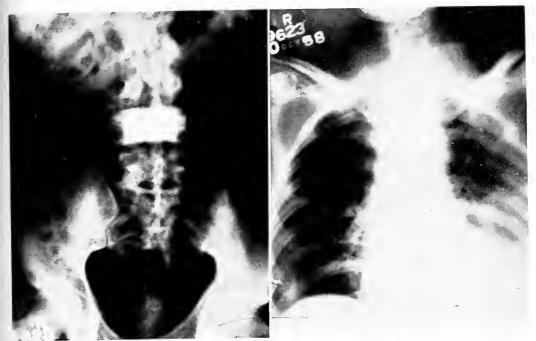


Fig. 4. Roentgenogram of the lumbar spine, showing sclerosis of the fourth lumbar vertebra.

Fig. 5. Chest roentgenogram showing metastasis in the left lower lung field.

sky units. After empirically administered radiation to the sclerotic vertebra afforded no relief of pain, surgical decompression of the fourth and fifth lumbar roots was performed (R. H. Ames, M.D.). At operation the bone appeared abnormally soft, but no definite tumor could be identified. The fifth lumbar nerve on the right was seen to be displaced by a mass of reddish soft tissue overlaid by large blood vessels. Biopsy specimens were described by the pathologist (H. C. Lennon, M.D.) as necrotic tissue, with only a few cells present. It was felt that these cells might be neoplastic, but their origin was in doubt, and they did not resemble adrenal cortical tissue.

The pain was temporarily relieved by the decompression, but recurred three months later, and left cervical cordotomy was performed. Soon after this procedure the pain became generalized on the contralateral side, and opiates were needed in increasing quantity. Sometime during the next several months an irregular abdominal mass was palpated, seemingly fixed to the anterior aspect of the third lumbar vertebra. Concurrently the patient began to complain of pain

in the left anterior part of the chest. Another exploration at the fourth lumbar vertebra was performed, and this time a mass of gray tissue arising from the anterior surface of the spinal canal was removed. Microscopically (H. Z. Lund, M.D.) there were atypical round and polyhedral cells. The diagnosis was undifferentiated carcinoma with reactive (probably radiation) fibrosis.

The patient was not made comfortable; he demanded opiates constantly, he had high fever daily, and systemic deterioration became pronounced. The total protein was 6.5 Gm. with 3.2 Gm. of albumin and 3.3 Gm. of globulin. The hemoglobin was now 10.3 Gm., cephalin flocculation was negative, and the alkaline phosphatase was 1.4 Bodansky units. Oral corticosteroid therapy was tried with striking success, and the patient was symptom-free for the next few months (this was three and a half years after removal of the tumor, and a year after the cordotomy). Pain subsequently developed in the left upper part of the chest and the left shoulder, and the irregularly shaped pre-lumbar mass grew larger. Hem-

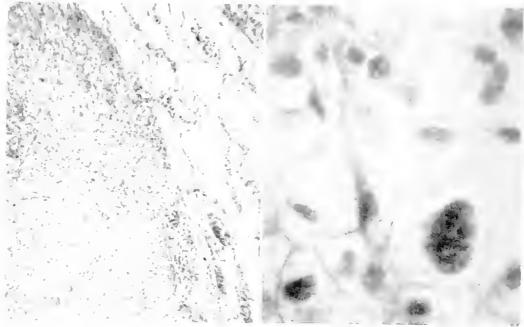


Fig. 6. Low power photomicrograph showing lung metastasis found at autopsy.

Fig. 7. High power photomicrograph of figure 6. Note similarity to figure 3.

oglobin was 9.6 Gm.; alkaline phosphatase was 5.8 Bodansky units; blood electrolytes, urinary 17 ketosteroids, and 17 hydroxy-corticoids were normal. A new sclerotic lesion in the first lumbar vertebra was noted on x-ray, and a few weeks later a lesion projecting into the left pleural cavity from the chest wall was demonstrated (fig. 5).

Marked dehydration, fever, anorexia, and wasting occurred. Terminally paraplegia developed, with paralysis of the bladder and rectum. The patient expired at 49 years of age, eight and one half years after the tumor was first detected, slightly less than four years after its surgical removal and identification, and 18 months after an isolated metastatic lesion in the fourth lumbar vertebra was recognized on x-ray.

At autopsy (J. Harrup, M.D.), metastatic carcinoma was found in the ribs, vertebrae, sacrum, lungs (figs. 6 and 7), liver, and cauda equina, the last by extension from the surrounding bone lesions. Overlying the lower vertebrae and sacrum was a smooth, round, deep purple mass measuring 20x15x12 cm. The right adrenal gland was normal. Generally, the lesions showed

extensive necrosis, but there were areas resembling normal adrenal tissue, being yellow and firm on the gross examination and revealing glomerulosa-like arrangement microscopically.

Comment

Adrenal cortical tumors are not infrequently found during routine autopsies. At times it is quite difficult to tell whether there is an actual benign tumor or merely cortical hyperplasia. Usually hyperplastic nodules are small, 1 to 2 cm. in diameter, and have a regular cellular arrangment. The benign tumors tend to be larger, have a definite capsule, present a disorderly architectural pattern, and show individual cellular variation in size, form, and staining characteristics. Likewise, it may be difficult to distinguish a malignant cortical tumor from a benign one. The only absolute signs for diagnosing malignancy, other than the presence of metastases, are invasion of either the capsule or veins. Relative indications of malignancy are necrosis. nemorrhage, calcification. pleomorphism. and atypical nuclei. Some authors believe that benign adenomas may undergo maligFebruary, 1960

nant transformation. The tumor of the case being reported showed capsular invasion initially, and it certainly appeared that the malignant area had arisen within by a large benign cortical adenoma. Such an appearance has been typical of the previously reported cases of non-hormonal adrenal cortical carcinoma.

Summary

A case of non-hormonal adrenal cortical carcinoma with osteoblastic metastasis to the fourth lumbar vertebra is described. The tumor was removed four and one half years after it was first discovered; metasases appeared two years later, and death occurred 18 months after that.

References

- Cahill, C. F., and Melicow, M. M.: Tumors of the Adrenal Gland, J. Urol. 64:1-25 (July) 1950.
- Wood, K. F., Lees, F., and Rosenthal, F. D.: Carcinoma of the Adrenal Cortex Without Endocrine Effects, Brit. J. Surgery 45:41-48 (July) 1957.
- Heinbecker, P., O'Neal, L. W., and Ackerman, L. V.: Functioning and Nonfunctioning Adrenal Cortical Tumor, Surg., Gynec. & Obst. 105:21-33 (July) 1967.
- Karsner, H. T.: Tumors of the Adrenal, Washington, D. C., Armed Forces Institute of Pathology Publication, 1989.

Silo-Filler's Disease

Report of Two Cases in Henderson County, North Carolina

> EUGENE G. EVANS JR., M.D. LESTER B. McDonald, M.D. and

RICHARD A. PORTER, M.D. HENDERSONVILLE

The following two cases are being reported in order to alert the medical profession to the occurrence of so called "silo-filler's disease" in this state. Curiously enough this rather prevalent agricultural hazard in its various modifications was not clearly recognized and defined by medical investigators until about 1956, at which time reports were first published in the medical literature by several different groups in the middle western states⁽¹⁾.

Report of Cases

Case 1.

A 65 year old white male dairy farmer was seen at his home on October 28, 1956, five days prior to admission, with a history of acute illness marked by severe cough and weakness during the previous two weeks. He dated his illness from the time he climbed an enclosed ladderway to the top of his silo, a distance of 40 feet. This act required about five to eight minutes. The silo was a permanent concrete tower-type structure, and had been rapidly filled with freshly harvested corn silage four days previously. The soil had been heavily fertilized with nitrogen that year and during the preceding several years. The silo and its con-

necting chute were enclosed and unventilated except for the opening at the bottom of the chute. Half way up the chute the patient began to feel extremely ill and reasoned that he must either climb down or up to the top where he could reach fresh air. He remembered that certain gases prevalent in recently filled silos were heavier than air, so he decided to go up. He reached the top, where he opened a window, put his head out, and revived. He stayed there about 10 minutes and then descended to fresh air as rapidly as possible.

Almost immediately he began to cough and to manifest symptoms similar to previous episodes which he called "asthma." From then on he became very weak, lost his appetite, and took to his bed. The cough became highly productive of thick heavy purulent sputum, but he denied having spit up any bloody sputum during the first week. His wife stated that his appetite had been very poor. He had been content to lie in bed, which was unusual for him. His temperature had been rising to approximately 100-101 F. each night, falling in the early morning hours, accompanied by profuse, drenching sweats. There had been no chest pain and dyspnea had not been pro-

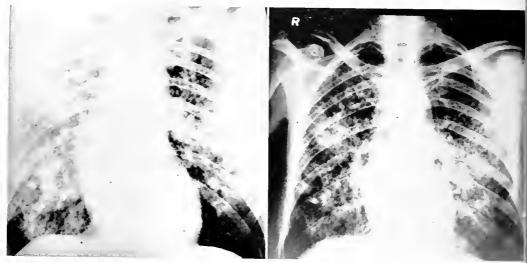


Fig. 1: Roentgenogram made on November 2 1956 at time of admission to hospital. Patient in recumbent position, 50 inch exposure. Marked multiple discrete infiltrative lesions scattered throughout both lung fields, more prominent in the right than the left.

nounced, but he had some shortness of breath after a protracted coughing spell. Beginning on October 28, 1956, he had been treated with intramuscular penicillin. 600,000 units daily for three days, with no improvement, then with oral oxytetracycline, 1.0 Gm, daily for two days; but his temperature was still elevated to 102 F. On the day before admission his sputum was slightly blood-tinged.

Past history: The patient had been a farmer for 10 years but had never had an experience of this type before, although he had heard of men becoming ill in silos. He had his first attack of asthma in 1930, following the plowing of a large area of brush and weeds. He stated that each winter thereafter he had an attack of what he called "influenza," with the development of asthma. He came from Florida to this connty in 1946 and thought he had escaped his usual winter illnesses; he rarely had colds, was able to work hard, and was seen by the attending physician in only two episodes of upper respiratory infection in six years (December, 1950, and May, 1952). both responding to three daily injections of penicillin. He stated that he had not seen a physician in the preceding three years,

Fig. 2: Re-examination of thorax on 11 November 1956. This and subsequent roentgenograms made in upright position with 72 inch exposure. Marked spotty infiltrative lesions. Little change.

and had had no colds during that time. He had never had pneumonia or pleurisy.

Physical examination: On admission to the hospital on November 2, 1956, the patient was a tall, lean, lanky white male who lay in bed and had every appearance of acute illness. His color was moderately good, and he was not particularly cyanotic. His cheeks were flushed. Respiration was fairly rapid (22 per minute), temperature 102.4 F pulse 100 beats per minute and regular, and blood pressure 110 systolic, 80 diastolic. The other pertinent physical findings were limited to the lungs: Breath sounds were harsh throughout; vocal resonance and fremitus were not those of consolidation, and there were a few crackling rales mixed with a few large bubbling rales.

Accessory clinical findings: Urinalysis was normal except for a trace of albumin. Blood studies indicated 14.05 Gm. of hemoglobin per 100 cc., and 18.200 leukocytes, per cubic millimeter, with 9 per cent stab cells. 79 per cent segmented polymorphonuclears, 5 per cent lymphocytes, 3 per cent monocytes, 2 per cent basophils, and 2 per cent eosinophils. The sedimentation rate of erythrocytes was 90 mm. in one hour (Westergren method). Three sputum smears for acid fast organisms were nega-

tive. Routine bacteriologic cultures of the sputum were reported as showing staphylococci, streptococci and diphtheroids, and cultures for fungi produced *Candida albicans*. Two cytologic studies of the sputum disclosed no evidence of neoplasm.

On admission a roentgenogram of the thorax (fig. 1) as interpreted by Dr. Karl Kaufman, radiologist, showed marked multiple discrete nodular infiltrative lesions scattered throughout both lung fields, more prominent in the right lung and right base, but also pronounced in the central portion of the left lung field.

Clinical course: Oxytetracycline given intramuscularly for two days, then oral chloramphenicol therapy was initiated and continued for 15 days. The patient remained acutely ill, with a febrile course characterized by baseline rectal temperature readings of about 101 F. and daily evening spikes to about 103 F., the latter accompanied by free perspiration, lethargy, and at times irrationality. He continued to have severe cough productive of a considerable amount of pink, frothy and mucopurulent sputum. At times the sputum was frankly blood-stained. Harsh breath sounds persisted throughout both lung fields. He feit very weak.

By November 11, 1956, there had been no appreciable improvement in the patient's condition. A chest film at that time (fig. 2) showed little change. On the same date corticosteroid therapy was begun, using 40 units of ACTH intramuscularly per day for three days, and concurrently 5 mg. of prednisone, orally four times daily. The latter was continued in the same dosage about six days, following which 5 mg. was given twice daily for the remainder of his hospital stay and a short time thereafter. The patient's condition improved dramatically within nine hours of the administration of the corticosteroid. He felt much better and his temperature dropped abruptly to normal the same day and remained less than 100 F. rectally thereafter. Nystatin was begun on November 13, and was also continued throughout his hospitalization and for a short time thereafter. While in the hospital he continued to show progressive improvement, although auscultatory findings in the chest persisted in various degrees. He was discharged on November 21, 1956. Several chest roentgenograms showed progressive and complete resolution of the previously described lesions. Two illustrative films are seen in figures 3 and 4 taken on November 14 and December 13, respectively.

Follow-up information is not as precise as might be desired, but the patient apparently continued to have some difficulty with weakness, coughing episodes productive of white mucus, and at times dyspnea, but his weight gradually returned to normal within the next two months. Treatment was conservative, consisting chiefly of standard expectorants.

He returned to Florida to convalesce for about seven weeks during February and March, 1957, and was next seen on April 3, with the same complaints and still had both inspiratory and expiratory musical wheezes in both lung fields. A repeat roentgenogram of the thorax at this time showed complete resolution of the infiltrative and fibrotic lesions in both lung fields, but a. slight increase in the small pulmonic markings was still present. Expectorants, bronchodilators, and a regimen of intermittent antibiotic therapy were used over the next several months with variable results, the usual findings on examination being some wheezes in the lung fields. He was last seen professionally on July 30, 1957, at which time his lungs were clear to auscultation. He is still living and working, but a medical report of his present status could not be obtained.

Case 2

A 50 year old white male dairy farmer (who lived only 2 to 3 miles from the patient in case 1) was seen at his home at about 9:30 P.M. on August 6, 1959, with a history of sudden smothering while eating supper a short time earlier. It was learned that he had filled his silo with wet green alfalfa and some clover and pasture grass during the previous day, and after letting it settle overnight had gone back the next evening just before dark for about 20 to 30 minutes to pack it down and level it off a little. This silo was a concrete tower-type structure similar to the one in case 1. In contrast, however, both the silo and chute were open at the top. The silo measured about 35 by 12 feet and held 95 tons of sil-

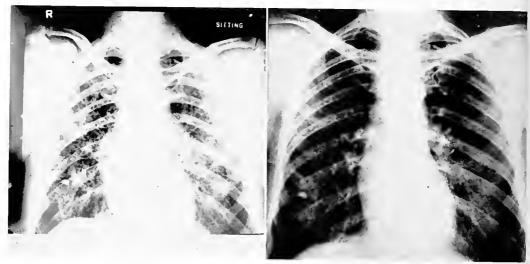


Fig. 3: November 14, 1956. This roentgenogram taken on fourth day of corticosteroid therapy.

age as opposed to 40 by 14 feet and a capacity of 125 tons in the first case. About 40 to 50 minutes after leaving the silo the patient noticed difficult breathing which he verbalized as: "Can't get air in . . . smothering . . . short of breath . . . having to breathe hard." He had no previous history of asthma or pulmonary disease except for "pneumonia" in 1930, but recalled having smothering spells, mostly at night, on about six occasions during the preceding month or so, which he attributed to "indigestion or gas." They were relieved by burping, and, unlike the present episode, they did not "close up and shut off" breathing. The dates of these episodes were rather vague, but may have occurred after the first alfalfa ensiling operation around the latter part of April or first part of May, 1959. At that time, however, he did not re-enter the silo for five or six days after the filling.

The patient was a well nourished, well developed male who was sitting up but having progressive intermittent dyspnea with frequent inspiratory gaspings for breath. His color was good, and he did not appear to be in pain. His temperature was 98 F., pulse 100 (strong), respirations 16, and blood pressure 140 systolic, 100 diastolic. Thoracic examination, disclosed some wheezes in both lung fields, left more than right, but no dullness to percussion and no

Fig. 4: December 13, 1956. Further resolution of previously described lesions. Increase in small pulmonic markings throughout both lung fields.

change in vocal sounds. The heart was not enlarged, and there was no arrhythmia or murmur. The remainder of the physical examination was not remarkable.

A 12-lead electrocardiogram taken at his home was entirely normal. He was given 100 mg. of Solu-Cortef (hydrocortisone sodium succinate) intravenously, and started on dexamethasone, 0.75 mg. four times daily, given orally at home, the latter being continued in decreasing dosage for a week. No antibiotics were given. He was seen in the office the following morning as directed, and still had some intermittent gasping, but this sympton was less pronounced than on the previous night. Auscultation of his thorax still revealed some wheezing sounds. A roentgenogram of the thorax was obtained at that time and was interpreted by the radiologist as being normal. Seen again three days later as instructed, the patient stated that he still had to take an occasional "deep breath all through the day." On physical examination then his lungs were clear. His symptoms had disappeared by August 14, 1959, and on subsequent examinations in September and October he had remained asyptomatic and his chest was normal on physical examination.

Comment

Several authors(1) have outlined the pertinent features of silo-filler's disease syndrome: Briefly they involve exposure to gas evolved from fresh silage during the initial fermentation stages of ensiling, beginning within a few hours after the start of a silo filling, reaching a maximum between one and two days later, and continuing at a decreasing rate for a week or longer. The irritating gas has been identified as nitrogen dioxide and its dimer nitrogen tetroxide. Several conditions thought to contribute to the high concentration of nitrates in plants under certain circumstances are listed as drought, high-nitrate soils, immaturity of plants, and increased length of photoperiod.

Lowry and Schuman^(1b) suggest that there is a continuous spectrum consisting of different types and degrees of bronchopulmonary injury by nitrogen dioxide dependent chiefly upon the amounts of gas inhaled and varying from: (a) acute pulmonary edema with death in less than two days, (b) edema and bronchopneumonia fatal before 10 days, (c) bronchiolitis fibrosa obliterans with death in three to five weeks, (d) bronchiolitis and focal pneumonitis with spontaneous recovery. (e) varying degrees of bronchitis and bronchopneumonia, and (f) chronic pulmonary fibrosis and emphysema.

Case 1 in the present report appears to correlate closely with the criteria for silage gas induced bronchiolitis fibrosa obliterans as outlined by Lowry and Schuman^(1b).

Case 2 in this report would appear to fall within the bronchiolitis and focal pneumonitis category.

The use of cortisone in addition to antibiotics and supportive therapy was suggested by Delaney and others (1a). Lowry and Schuman (1b) mentioned the apparently favorable response to corticosteroids noted in 2 of their 4 cases. They cautioned, however, that the diagnosis of silo-filler's disease must be assured before corticosteroids are used, because widespread infections, particularly miliary tuberculosis, may create a similar x-ray picture (and sometimes a similar clinical picture as well). Grayson's case of acute pulmonary edema (1c) was treated with conventional

methods, plus hydrocortisone (Contef) administered intravenously, but the patient failed to respond to the latter and expired 29 hours following exposure to the silage gas, thereby confirming Lowry and Schuman's statement that exposure to the higher concentrations of silo gas or nitrogen dioxide is rapidly fatal in spite of any treatment. Corticosteroids seemed to be very effective in both our cases. It is interesting to note that the previously cited cases of nitrogen dioxide poisoning due to inhalation of fresh silo gas concerned corn silage. Our first case involved corn silage but the second concerned the legumes, alfalfa and clover, together with some pasture grasses. Rather and Harrison(2) state: "The most noteworthy characteristic of legumes is the association with them, in nodules or tubercles growing on roots, of symbiotic bacteria which have the power to fix the free nitrogen from the air into forms that can be utilized by the plant. Because both the seeds and the leaves of legumes are characteristically high in nitrogen, this family of plants has an important place in livestock feeding."

Summary and Conclusions

Two cases which we think conform to the established criteria for particular forms of silo-filler's disease are presented. Both cases involved exposure to fresh silage and illustrate certain results of exposure to varying concentrations of the gas (nitrogen dioxide) in tower silos, and point out the apparently favorable effect of corticosteroid therapy in these instances. They also emphasize the need for the dissemination of more concrete information about the potential dangers to persons engaged in ensiling.

Agricultural methods have been revolutionized in recent years, and an understanding of certain procedures involved may help to explain the possibly increasing incidence of silage gas poisoning. The two dairy farmers in the cases here reported pointed out several enlightening observations to one of us. They stated that formerly in harvesting they would slowly progress through the separate stages of cutting, binding and hauling the crops, and then filling their silos, the total process requiring about a week (depending upon the number of workers and other factors).

Now with the use of mechanical forage cutters and blowers there is rapid harvesting, cutting, and filling of the silo, all phases of which can be accomplished within a single day. They stated that in the last several years they had used heavy nitrogen fertilization on their corn crops. (The commercially available bacteriologically inoculated legumes do not of course customarily require the addition of heavy soil nitrates, since they have the ability to gather free nitrogen from the atmosphere: however, additional phosphorus, in the form of superphosphate, and potassium, in the form of potash, were used.) They concluded that the additional soil nitrogen plus the speed-up in the over-all harvesting and ensiling operation caused more nitrogen to react all at once. In regard to the opinion that the more intensive use of fertilizers may be causing increases in plant nitrogen, a clarifying communication from the fertilizer-research division of the Tennessee Valley Authority is pertinent:

"A brief review by our research staff of literature on plant analysis as affected by fertilization indicates that excessive accumulation of nitrogen in plants is not a common occurrence, although it is known that nitrate buildup may occur under unusually droughty conditions. In general, plants do not take up and utilize more nitrogen than is required to achieve the particular level of dry matter production that is possible under the prevailing climatic and soil conditions. There is generally a high correlation between nitrogen and phosphorus contents of plant tissue, suggesting that each regulates the uptake and utilization of the other."

Precipitation statistics for this area obtained from the United States Department of Commerce Weather Bureau were examined by one of us. Although a formal statistical and scientific analysis of these detailed tables was not performed, they were not interpreted as representing the prevalence of drought conditions during 1956 and 1959. The local county farm agent, Mr. D. W. Bennett, was also consulted for technical advice, with special reference to preventive measures. He stated that for three or four years he had been recommending horizontal rather than tower (upright) silos, pointing out that the latter were much more expensive and no more durable than one of the horizontal variations (trench, bunker, etc.). He felt that well ventilated horizontal silos would be one practical method of dealing with the problem. He stated that since the 1956 case of silage gas poisoning in this county, his staff had been cautioning farmers about going into their silos within the first week after filling.

References

- (a) Delaney, L. T., Jr., Schmidt, H. W., and Strobel, C. F.: Silo-Filler's Disease, Proc. Staff Meet, Mayo Clin. 31:189-198 (4 April) 1956, (b) Lowry, T., and Schuman, L. M.: "Silo-Filler's Disease"—A Syndrome Caused by Nitrogen Dioxide, J.A.M.A. 162:153-160 (15 September) 1956, (c) Grayson, R. R.: Silage Gas Poisoning: Nitrogen Dioxide Pneumonia, A New Disease in Apricultural Workers, Ann. Int. Med. 45:393-408 (September) 1956.
- Rather, H. C., and Harrison, C. M.: Field Corps, 2nd ed., McGraw-Hill Book Company, Inc., New York, 1951.
- Personal communication from L. G. Allbaugh, Director, Division of Agricultural Relations, Tennessee Valley Authority, Knoxville, Tennessee (13 November) 1959.

Preparations containing more than three ingredients may usually be regarded as therapeutically unsound. Those that may be acceptable are certain analgesic compounds such as acetylsalicylic acid and acetophenetidin, as well as preparations containing the essential vitamins in their recommended dosage. Preparations containing more than vitamins A, D and C, thiamine, riboflavin, niacinamide and perhaps pyridoxine should, however, be looked upon with suspicion, since they are, for most part, of unproved value and expensive; those with two dozens or more ingredients border on the ridiculous. It is time to discontinue such topheavy polypharmacy. Friend, D. G.: Polypharmacy—Multiple-Ingredient and Shotgun Prescriptions, New England J. Med. 260:1017 (May 14) 1959.

The Role of a Physician in a Changing Society

HUGH A. MATTHEWS, M.D.

CANTON

A good case can be made for Health instead of the Great Jehovah as the god of America. That Health is the prime interest and perhaps the final devotion of the American people is evidenced in many areas. In mass information media—whether press, radio or television—health is constantly among the most popular subjects. The talented author with a doctor story has a good bid for a best seller.

In American industry today management has no choice but to participate in the health field. Labor senses the importance of this god and uses him at the conference table and elsewhere. God Health holds promise of even greater power in this area.

In the agricultural world, God Health is no tottering idol. Thirteen years ago rural America was demanding more consideration for rural health, and was willing to approach the hand of the federal government if no other appeared.

Perhaps the best place of all to discover the relative importance of Health is at the bridge table, in the Woman's Missionary Society, or even the barber shop. In these settings none need be a wallflower. The mere mention of an operation, a new health insurance policy, a new wonder drug, the merits or demerits of a certain doctor, the cancer clinic, or the polio drive puts the informer in the limelight.

Perhaps if the Great Jehovah were sought and found, the solution to America's health problems would be at hand. If enough citizens were seekers, even the process of seeking would likely make Pfizer stock drop precipitously and put Wallace Laboratories out of business. This is not mine to contend. It is mine to accept the situation as it is and analyze the role of the physician in this atmosphere.

At least the minister, priest, or rabbi who wishes to keep his post will be smart to dwell much on health. If he wishes to make the best-seller list or television, he had best dwell on health all the time.

Read before the Section on Practice of Medicine, Medical Society of the State of North Carolina, Asheville, May 6, 1959. From the Midway Medical Center, Canton, North Carolina. What in present day America is this goal or god, as the case may be, which is so much desired?

Until about the middle of the nineteenth century, health was considered the mere absence of pain. The physician's role was to give symptomatic relief. He applied leeches, bled, and purged. He applied mustard plasters, ointments, and cupped. The physician was the exclusive dispenser of health, who grew or made his agents for relief.

At the middle of the ninetenth century disease, not symptoms came increasingly to receive the spotlight. Bacteria became known entities. Cause and effect operating in human subjects became the burden of doctors.

Others necessarily became essential to the health program. Bacteriologists pathologists, technicians, even manufacturers, became increasing important. Focus on disease made finding the source of causative agents, and ways and means of prevention, all important. Public health services became essential to the health sciences. In many states, sources of disease were found to be the responsibility of municpal, county, state, and federal governments. In meeting this responsibility, sanitarians, entomologists, sanitary engineers, and other groups became a part of health activity.

Health then became the absence of disease. At the turn of the century, the nation was germ-conscious. Demand was greater, knowledge was greater, and equipment increasingly necessary. Physicians, communities, foundations, and governmental agencies were building hospitals. The nursing profession increased by leaps and bounds. Hospital administration, as a profession, had its birth. Now medical expense involved more than doctors' bills, the pharmacist, the hospital, the nurse, and others had to be paid.

To relieve the financial burden, prepayment medical schemes came into being. Insurance business entered the field of health to stay.

The disease in a man could not be observed until the man was seen. As the twentieth century progressed, medical science was focused not merely on man's symptoms or on his disease, but primarily on man himself. His nutrition, his mental state, his genetic inheritance, and economic and social status were found to be important factors. Scientific clinical medicine now accepts and teaches the concept of the whole patient—physical, mental, and social—as the central object of medical practice.

Health has come to mean a state of harmony with one's self. The term "medicine" now implies pyschosomatic medicine.

In the middle of the twentieth century, of which we are a part, God Health is taking on another dimension. Psychosomatic man still stands in the spotlight, but somewhat off center. The light is shifting to the health needs and status of the community.

Dr. Edward G. McGavran, head of the Public Health School of the University of North Carolina, with a profound sense of the sociologic aspects of health, says: "In scientific public health, we no longer treat the individual—the segment of the community—but the total body politic—mental, physical, social and economic."

A revision of the "Principles of Medical Ethics" was adopted by the House of Delegates of the American Medical Association in June, 1957. Section 10 of these Principles reads: "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where the responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community."

The present day physician is in a state of change which demands a broadened conception of his role. In every transition in the focus of interest, eminent physicians have rebelled. Change nevertheless took place. History has proved that to ride on the wave of change is folly, to resist change is fatal, but to predict and fashion change is fruitful.

In early America the strongest social unit was the neighborhood. Physiographic conditions, family ties, and other factors brought individuals together. To get what

they wanted they evolved social institutions—the school, church, grocery store, and the blacksmith shop. The system geared to its time obtained the objectives desired.

Under the impact of technology neighborhood life is giving away. The most eminent new social system is the town-country community, the type of community in which most of us live. Rural people are moving near the city to work. Urban people are moving out of the city to live, but maintain their jobs in town. Industry is decentralizing by moving to the suburbs and smaller communities. Communities everywhere have industrial development committees.

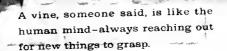
A revolutionary change is taking place in the public school system. The American people, as one man, are acting on the assumption that a complete community must have a high school, a junior high school, and an elementary school, the entire system operating to serve the given community.

Along with the school are many other community organizations and services. Recreational programs, service clubs, national health foundation chapters, and many special interest groups concern themselves increasingly with health and welfare. Hospital services, water supply, sewage disposal, safety, fire protection, and health clinics are the constant concern of organized groups.

While every man belongs to a community of family, neighborhood, county, state, nation, world, and now possibly of the universe, the community described above is the one coming into focus on the medical scene. Virtually all the people and all the organizations of this community concern themselves with health. The era is at hand when team effort is essential and will be had.

Medical Care— The Physician's Responsibility

The primary role of the physician on the team is medical care. The term "primary" is emphasized and haste made to add that medical care of necessity is his primary but not his exclusive role. His specific training is to administer medical care, and in this role he is most urgently needed. He will have to remain dedicated primarily to suturing the face that has been cut, treating the diabetes of the obese patient, or controlling the spread of typhoid from



BUIRESS

One way or another people will seek out new ways to cope with old problems. Yet progress must be wisely guided. One doctor says: "The desire of the public to have prepayment medical protection is so urgent that it will buy this protection from whatever plan seems most enticing. Whether you like it or not, prepayment medical care is here to stay. Let us support the system which is voluntary and over which we have adequate control." BLUE SHIELD



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polluted water. In chronic illness, the majority of physicians will have to expend most of their energy in treating the end results of aging or disease processes.

In answer to the demand for a team approach to health problems, the American physician should be willing to serve as captain of the team, not as a privileged character, but as a servant. He should be willing to bring the team together. From communication will come mutual helpfulness and definition of roles.

The physician should and must become an expert in legitimation. Frequently, all an organization wants from the doctors with respect to a health project is the green light. The green light should be given if the project is worthy of the effort. If the project is not worthy, deserving interest can be redirected to a deserving end far easier than it can bucked.

In this era of change of focus to the newly developing community, the physician needs to interpret his role to the health team. He must help younger members of the team find and define their roles. With the team, through communication and not boycott, he must and can preserve his honored and historic place in health on the march.

The latest Health Man-power Chart Book of the United States Department of Health, Education, and Welfare states, "Nearly two million persons are employed in occupations considered in the health

field." Among these are dentists, public health nurses, health engineers, health eduand psychiatric case cators. medical workers, nutritionists, sanitarians, and laboratory technicians. Of the nearly two million health workers, perhaps less than two hundred thousand are practicing physicians.

Even so, if Health is the God of America, the doctor is the priest. All major health organizations and the people of the community want him at the head of the team. If the doctor fails, the health system of this country as it is now known and wanted has failed. The people will make this choice. Interference in physician-patient relationship in certain areas must not be interpreted as a calamity but as a challenge.

The people demand much in health. Two million trained health workers stand ready to help two hundred thousand doctors.

At the recent Lions' Convention in Chicago, a beautiful blind girl with a beautiful voice was soloist. The Minneapolis Lions Club had financed her training at a university and the Juilliard School of Music. When she appeared on the stage, her poise and charm, coupled with the appeal of her blindness, brought the hush of a baptismal service over thousands of men. Soon over the rough faces of America's rugged business men tears began to fall.

The blind soloist sang-"Never Walk Alone."

Dr. Watson S. Rankin

W. C. DAVISON, M.D. DURHAM

It is a great pleasure for me to be present at the dedication of this new health center. Because the Charlotte and Mecklenburg County Health Department is generally regarded by the United States Government as one of the best in the country, many of my friends from China, Formosa, and other foreign countries have been sent here to study your methods. All of them have been enthusiastic in your praise.

My pleasure is increased by the fact that this building is named for Dr. Watson Smith Rankin, a leading pioneer in health work who has been more than a father to

And finally, my cup runneth over because Dr. Hamilton W. McKay, Dr. M. B. Bethel, and Dr. Elizabeth C. Corkey invited me to talk about Dr. Rankin, who is my favorite subject.

Talk made at the dedication of the W. S. Rankin Health Center of Charlotte and Mecklenburg County on Dr. Rankin's eighty-first birthday, January 18, 1960.

From the Department of Pediatrics, Duke University Medical Center, Durham, N. C.

I first heard of Dr. Rankin and his accomplishments in 1916. At that time the public health program of this country needed a strong leader, and Dr. William H. (Popsy) Welch, professor of pathology at the Johns Hopkins since 1883, was chosen by the Rockefeller Foundation to be named professor of public health at the Hopkins. He told me that his only qualification for his new appointment was that two of his pupils had become outstanding in the field of public health-namely, Walter Reed of yellow fever fame, and Dr. Watson S. Rankin, the first full-time state health officer of North Carolina and the best in the nation.

I did not have an opportunity to meet Dr. Rankin until 1926, when the Southern Medical Association met in Atlanta. Since Dr. Rankin knew that I was being considered for the deanship of the Duke Medical School, he and Dr. Paul Anderson slipped into the Section on Pediatrics to hear me talk on the selection of medical students-then, as now, a controversial subject. Since I knew that Dr. Rankin was a trustee of the Duke Endowment and would be one of my bosses if I were appointed, I slipped into the Section on Public Health the next day to hear him talk on the needs of rural medicine. That evening Dr. Paul Anderson introduced us, and Dr. Rankin and I formed a two-man mutual admiration society and a fatherand-son relationship. For thirty-four years he has been the second "light of my life," a title which Osler gave my wife in 1914.

The printed program for this dedication contains the bare facts of Dr. Rankin's splendid career, which are listed modestly in WHO'S WHO IN AMERICA. He has received many honorary degrees, and has held every office available to leaders in public health, having served as president of the American Public Health Association and of the Association of State and Provincial Health Officers, and chairman of many national and state health committees.

The program, however, cannot begin to record Dr. Rankin's many accomplishments. With the help of my friends, Marshall I. Pickens, F. Ross Porter and F. Vernon Altvater, who also pride themselves on being sons of Dr. Rankin, I have garnered considerable information about

these accomplishments and shall mention just a few of them.

In 1905, malaria was such a menace to the citizens of North Carolina that Dr. Rankin went to Panama and climbed all over the canal excavations with Dr. Henry Carter — who, more than General Gorgas and General Goethals, was responsible for the success of the mosquito control program and the eradication of yellow fever in Panama. When Dr. Rankin returned to North Carolina and applied Dr. Carter's methods of mosquito control, the incidence of malaria rapidly declined. After the Panama Canal was finished, Dr. Rankin persuaded Dr. Carter to become the malaria control officer for the Duke Power lakes. None of us would have known of this great contribution to public health if Ross Porter, my wife, and I had not visited Panama with Dr. Rankin three years ago, while on a Duke medical postgraduate cruise, and Dr. Rankin pointed out the landmarks of that earlier visit.

Most of the hospitals in other states are worrying about the stiff standards imposed by the Joint Commission on Accreditation, but in North and South Carolina these standards were gradually and painlessly developed twenty years ago by Dr. Rankin and his staff in the Hospital Section of the Duke Endowment.

Until 1924, many of the hospitals in the Carolinas had been built and maintained by pioneer surgeons who had invested their life earnings in them. Dr. Rankin wisely persuaded the communities, with the help of the Duke Endowment, to buy these hospitals and to maintain them as a community responsibility. As a result of this program and his knowledge of the medical and hospital needs of North and South Carolina, and his plan of community hospitals based on his visit to Dr. Maurice M. Seymour in Canada, the Carolinas have better hospital facilities than most of the other states in the nation.

It is perhaps not generally known that the hospital program of the Duke Endowment, developed by Dr. Rankin, is the model followed by the Hill-Burton bill. Dr. Thomas Parran, then Surgeon General of the United States Public Health Service, and Dr. Vane Hoge, Hospital Director of the United States Public Health Service, toured North Carolina with Dr. Rankin in

1936 and 1937 so that they might study the Duke Endowment program. This program, together with Mr. Duke's emphasis on local responsibility for local hospitals, has been the keystone of the Hill-Burton program.

Rising hospital costs (ours at Duke went from \$3.81 per patient day in 1933 to \$24.55 at present) would have bankrupted hospitals all over the country if it had not been for the Blue Cross program, which Dr. Rankin fathered by helping to develop Dr. Tom W. M. Long's pioneer plan in Roanoke Rapids of a weekly pay deduction of twenty-five cents per employee for hospitalization. With the help of Dr. Rankin and the Duke Endowment, this plan grew into the Hospital Care and Hospital Saving Associations, which are models for Blue Cross plans in other states.

Dr. Rankin's interest in medical education has been of inestimable help to the Duke University Medical Center, as well as to medical schools everywhere. In 1926 a former president of the American Medical Association advocated the establishment of a series of second-rate medical schools throughout the country, whose graduates would not know enough medicine to practice in the cities. Dr. Rankin promptly invited him to tour North and South Carolina, in order to show him that good medical care is just as necessary for rural areas as for cities, and that it was being provided with the aid of community hospitals which attracted keen medical graduates to small towns.

Dr. Rankin also is responsible for the youthfulness of the original Duke medical faculty. He and I had both learned from Osler that a keen young man would make a better medical teacher than one who was more mature and who might be inclined to rest on his laurels; consequently, whenever we had a choice of candidates, the younger man was selected. As a result, the average age of the original Duke medical faculty was 34 years—the same as that of the

original Hopkins faculty. Dr. Rankin himself is the best example of youth—he was only 24 years of age when Dr. Welch recommended him for the professorship of pathology at Wake Forest, 26 when he became dean of the Wake Forest Medical School, and 30 when he was made North Carolina's first full-time health officer.

One more anecdote: Dr. Rankin's career in public health was launched by the hookworm. While in Baltimore, he performed one of the first autopsies in this disease and later at Wake Forest he found it in many patients. As a result, he became so much interested in preventive medicine that Dr. R. H. Lewis, chairman of the North Carolina State Board of Health, was able to persuade Dr. Rankin in 1909 to become one of the first full-time state health officers in the United States.

Incidentally, I also received my appointment by way of the hookworm. In 1925, after Mr. James B. Duke died, Dr. William P. Few, president of Trinity College (later Duke University), was faced with the problem of starting a medical school. Fortunately for me he knew Dr. Wickliffe Rose, who was in charge of the hookworm campaign in North Carolina, which Dr. Rankin had started. Dr. Rose referred Dr. Few to Dr. Welch, who persuaded Dr. Few to appoint me as dean, thereby completing the life cycle of the hookworm—now a forgotten disease.

Hookworm and malaria will pass into oblivion — thanks largely to Dr. Rankin's efforts—but this new W. S. Rankin Health Center will remain as a monument to the man who has done so much to improve the health of the citizens of North and South Carolina. The dedication of this building is a fitting tribute to him on his eighty-first birthday.

Last but not least. Dr. Rankin started as a Presbyterian, became a Baptist, now works for the Methodists, and everyone loves him.

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FEBRUARY, 1960

COUNTY MEDICAL SOCIETY OFFICERS' CONFERENCE

The first annual conference of County Medical Society Officers, held in the Carolina Hotel at Pinehurst on Saturday, January 30, was appropriately entitled "Navigating the Medical Waters." Rain began the night before and continued steadily until the next day. In spite of the weather, however, there was a good attendance, and the enthusiasm of the men present was not dampened. The wives, however, were quite disappointed in being shut in for the week end.

Thanks to the chairman, Dr. E. T. Beddingfield, the Conference was run on schedule and closed promptly at 4 o'clock.

Perhaps the high light of the program was a comparison of the American and the British system of medical care by Dr. John C. Duke. Dr. Reckless, who has practiced

under both systems, gave an illuminating discussion which was appreciated by all. While he gave the pros and cons of both, he left no doubt as to his preference for the American system.

Dr. Donald Koonce gave excellent advice on the "Modus Operandi of County Societies." Dr. Wayne J. Benton spoke on finances and explained the way in which the Society's income is received and how it is spent.

Mr. C. A. McKnight, editor of the *Charlotte Observer*, gave "A Non-Medical View of the Profession"—an excellent opportunity to see ourselves as others see us.

Dr. Leonard Martin (Ph.D.), assistant director of the Economic Research Department, American Medical Association, gave an analysis of the cost of medical care in which he showed that the doctors' share of money spent for medical care is much smaller than is generally believed.

In the panel discussion of insurance more questions were raised than were answered, but at least the conference members gave it close attention. Among the questions raised was whether or not the cancellation of so many policies by some companies is justified; why some companies reject the standard forms prepared by our Society: and how to determine the validity of claims for diagnostic surveys. Insurance for the home-care of patients when authorized by the physicians was advocated. Mr. Charles Gold, State Commissioner of Insurance, was asked how many riders should be attached to a policy for holders past 65. His reply was, "not more than one."

The question as to whether patients abused hospital insurance was given a sort of "yes and no" answer. A good many thought that insurance companies would save money by paying for some diagnostic procedures, especially x-rays, without requiring the patient's admission to the hospital.

"Successful Local Projects" of seven counties proved to be most interesting and stimulating. The projects discussed were: "Medical-Legal Cooperation in Forsyth County," Julius A. Howell, M. D.; "Medical Press Relations in Wilson County," William G. Spencer, M. D.; "Health Fairs and Scholarships, A Community Project in Haywood County," Hugh A. Matthews. M. D; "A Welcome Wagon Letter to New

Residents," W. J. Senter, M. D.; "Cooperation with the Welfare Department in Harnett County," Bruce B. Blackmon, M. D.; "Science Fair Sponsorship in Mecklenburg County," James P. Alexander, M. D.; "Cabarrus County Projects, Tetanus Program and Uterine Cytology Survey," M. S. Tuttle, M. D.

The final message from President John Reece is to be published in the NORTH CAR-OLINA MEDICAL JOURNAL and will well repay reading, even to those who heard it.

A movie, "On Call to a Nation," BBC Documentary Report on the British Medical System, was scheduled for 7:30 P.M. but did not get under way until after 9 o'clock. Only a comparatively few saw it, but those who did agreed that it confirmed the viewpoint of Dr. Reckless.

The verbal comments on the Conference were generally favorable. Its effects will be far-reaching if the county officers present will take back home with them the information and inspiration offered by the program participants.

Guest Editorial PLANS FOR MORTALITY STUDIES IN 1960

Most of us have been eye witnesses to the scientific revolution taking place in the twentieth century. We have seen the wide use of automobiles, the automation of industry, the mechanization of the household, and, in medicine, the introduction of antibiotics, new chemotherapeutic agents, and new techniques in diagnosis and surgery. Mortality statistics recorded for the first half of the century show clearly the effects of medical advances on improvements in health. But we know nothing of the effects on longevity of differential changes in standards of living, or of our new way of life. More than one hundred years after Dr. William Farr pointed out the relation between levels of living and mortality, the vital statisticians in the United States have not achieved a satisfactory measure of mortality for the socioeconomic groups of our population.

The information on the death certificate can be and has been used to determine death rates by cause of death, age, sex, marital status, and, for persons of work experience, by broad occupational groups. But there is no information on the death certificate that enables us to relate the mortality of women and children to the occupation of the husband or father, or to relate the mortality of any group of education, income, housing, size of family, and other important socioeconomic variables.

The most comprehensive source of socioeconomic information about each person and his family is the decennial Census of Population in which, for 1960, about 180 million persons in 54 million households will be enumerated. A proposal has been made for a new type of mortality study that would utilize the information collected in the April 1960 Census. For a selected period after the enumeration date, the census records of persons who were alive at the time of the census but who died in the months immediately following will be located. The information on the census record will be correlated with the information on the death certificate. This matching procedure will expand tremendously the number of variables that can be related to the cause of death reported by the physician on the death certificate.

The key to the linking of the death record and the census record is the address of the decedent. The census records are filed according to the enumeration district (the area of a city or county assigned to one enumerator) in which the family lived. The enumeration district in which the "usual residence" of the decedent given on the death certificate is located can be identified. Then this enumeration district file will be searched for his address, his family and the individual. When the decedent is located, the statistical information from both records can be brought together mechanically. It is important to note that this procedure preserves the confidential nature of the census record and of the death certificate. The additional information that could be obtained by matching the 1960 death and census records enhances the value of that basic demographic document, the death certificate. These data may establish the beginnings of a new series of rates reflecting the effects of our twentieth century way of life.

CURED CANCER CONGRESS

At a meeting of professional men a highly intelligent lawyer said that he had never known a person who had been cured of cancer. The man sitting next to him immediately said: "Well, you see one now. Look at this scar on my face, which marks the spot where one was removed many years ago."

It is unfortunate that so many people share the view of the lawyer and so few patients freely admit that they have ever had cancer.

One of the most constructive moves made by the American Cancer Society is to sponsor a number of cured cancer congresses, with patients who have been cured selected to represent a variety of cancer types.

The first such congress for North Carolina is to be held in Raleigh at 7:00 p.m.. March 26, at the Sir Walter Hotel. Letters have been sent to all presidents of county medical societies, to chairmen of county society cancer committees, and to the medical advisers of several county units of the American Cancer Society. These men were asked to select patients who have had no recurrence of cancer for at least five years, and who were willing to attend the state congress as living, tangible evidence that cancer can be cured. From the case reports submitted will be chosen as wide a variety of cancer types as possible.

It is hoped and expected that the publicity given this congress will do much to dispel the unwarranted fear and ignorance of cancer that is so widespread.

WHICH PATH TO MEDICAL SECURITY?

It is now 20 years since the medical profession gave birth to prepaid medical care, but its ultimate patterns of operation and control are yet to be determined.

While most of us recognize that the public will make the eventual decision, nevertheless we doctors have it within our power—if we will—mightily to influence that decision. For the simple fact is that, in the long run, the people—our patients—will support that system of medical care prepayment which offers them the best assurance of satisfactory professional service through physicians and institutions of their own choosing.

Today, several contrasting programs of medical prepayment are competing for popular and professional favor—each embodying a distinct concept of the relationship between patient and doctor.

One such program is the limited cash reimbursement program of the insurance industry, which offers the insured certain dollar indemnities against certain medical contingencies, irrespective of the physician's charges for the service required.

Another major program is medicine's Blue Shield Plan, which seeks—through professionally negotiated schedules of payment and, in most areas, through the agreement of participating physicians—to assure the patient of fully paid professional services.

A third program is the "closed panel" of physicians. Operating frequently under labor or other lay auspices, this plan undertakes to provide a comprehensive service through a selected group of physicians remunerated by salary or per capita allowances, regardless of the volume of service required of them.

Which of these programs most faithfully reflects the traditional pattern of American medical practice? Which program is most clearly motivated—as medicine itself is motivated—to render service to the patient and to meet the needs of all segments of the community? Which program returns the fullest value to the patient and most fairly compensates the doctor? Which program best utilizes and protects the modes and ideals of practice that have earned us the envy of others?

SILO FILLER'S DISEASE

The paper on Silo Filler's Disease in this issue, by Dr. Evans, McDonald and Porter, deserves special mention. It calls attention to a comparatively recent occupational hazard of farming. The authors have given a vivid description of two types of the disease. They had the clinical acumen to profit by their experience with the first case and recognize and treat promptly their second one. Evidently they have been helped by keeping up with the current medical literature.

Such case reports are valuable. The editorial board of the NORTH CAROLINA MEDICAL JOURNAL is glad to accept such worth while contributions as this one.

Clinicopathologic Conference

Forsyth County Heart Symposium, Winston-Salem, October 9, 1959

Monroe T. Gilmour, M.D.
CHARLOTTE
and
ROBERT W. PRICHARD, M.D.
WINSTON-SALEM

IDIOPATHIC MYOCARDITIS

Clinical history: The patient, a 41 year old white man, was in relatively good health until three and a half years before admission, when he began to have cough and exertional dyspnea. These symptoms progressed for six months. At this time he first consulted a physician, who treated him with antibiotics for a respiratory infection, with slight improvement. Shortly thereafter congestive heart failure, with mild dyspnea and slight enlargement of the liver developed. The heart was enlarged to percussion and on fluoroscopy. The blood pressure was 120 systolic, 90 diastolic, and the pulse was 126 and regular. An internist was consulted, and gave a diagnosis of probable silent myocardial infarction. The patient improved on a regimen of diuretics, digitalis, and rest. During the next year his heart continued to enlarge, although the symptoms remained under control and he was able to do light work. Until the final admission he intermittently manifested various signs of failure, largely consisting of basal rales and slight ankle edema. His heart continued to enlarge, and about two months before the final admission the dyspnea increased and he had a systolic gallop rhythm, a severe cough, and increasing orthopnea and insomnia.

Immediately before his admission to the North Carolina Baptist Hospital he was a patient in another hospital, where his pulse was found to be 120 and regular, with a "definite diastolic gallop rhythm." He was treated for congestive heart failure and improved markedly, losing 14 pounds of weight during the first hospital week. After the first few hours his temperature was normal throughout his hospital course. Then left-sided hemiparesis and coma suddenly developed and he was referred to the

North Carolina Baptist Hospital.

Physical examination: The patient was an unconscious white man who could move

his right side but had complete paralysis on the left; he responded occasionally to loud stimuli. The temperature was 100, pulse 110, respirations 24, and blood pressure 120 systolic, 84 diastolic. The pupils were equal and regular, and reacted to accomodation and stimuli. The fundi showed slight venous engorgement. His neck was rigid. His chest expanded poorly. The heart was enlarged 2 cm. lateral to the mid-clavicular line in the fifth interspace. There was diastolic gallop rhythm at the apex. with no murmurs. The abdomen was soft, giving evidence of recent weight loss. There was no peripheral edema.

Accessory clinical findings: The urine was normal. The hemoglobin was 15 Gm., sedimentation rate 10 mm. per hour, platelets were adequate, the white blood cell count was 8,300, with a normal differential. The white cell count rose to 17,000 on the third hospital day. The blood urea nitrogen was 22 mg. per 100 cc., and the total serum proteins were 7.2 Gm., with a normal albumin-globulin ratio. The carbon dioxide combining power was 15.7 mEq. per liter, chlorides were 98.4 mEq. per liter and sodium was 136 mEq. per liter. A second blood urea nitrogen determination done the following day was 32 mg. per 100 cc. The coagulation time was 10 minutes, and the prothrombin time was normal.

A lumbar puncture was done, revealing a normal pressure of 110 mm.; protein, 58 mg. per 100 cc.; sugar, 92 mg. per 100 cc.; and a total cell count of 11, with 10 red cells. Fluid was grossly clear. An electrocardiogram showed sinus tachycardia with rare premature beats, first degree atrioventricular heart block, and left axis deviation.

Hospital course: On the second hospital day the patient responded slightly to stimuli and said a few words. Digitoxin and Diuril were continued. He became progressively more febrile, the temperature rising to 105 F. on the fifth hospital day. Measures to lower the temperature were ineffective, and the patient died quietly. Terminally there were Cheyne-Stokes respirations and marked tachycardia.

Clinical Discussion

Dr. GILMOUR: I must say that our patient has been allowed to say very little for himself. One would get the impression that his Boswell, in presenting this case,

was more concerned with a laboratory specimen than with the articulate, puzzled, and progressively sicker human being we are considering this afternoon. For this patient went from good health to chronic illness to death in an amazingly uncomplaining fashion, a fact which may itself be significant.

At 38 years of age we see him first, relatively young and always healthy, with no history of significant illness. We see him becoming troubled by a cough and slight shortness of breath on exertion, which is not severe enough even to cause him to consult a physician for six months. When he does consult a physician, one of the miracle drugs works no miracle, and because his improvement is only slight and not sustained, he again seeks medical advice. On this occasion, after a somewhat more exhaustive study, another type of treatment is instituted, and seems to help. In order to do even light work, however, he finds it necessary for the next two years to remain under medical supervision and to rest a great deal. All in all he had to take care of himself so carefully that it must have become increasingly apparent to him, as he noted recurrent cough, poor wind, and occasionally some swelling of his ankles, that whatever the illness was, it was far from cured.

Two months before his final hospital admission all these symptoms became aggravated to such a degree that he was unable to sleep—a situation which led at last to his admission to a hospital. Here he was greatly encouraged by his progress. He lost 14 pounds of weight in one week and was able to breath a great deal better. Then, just as he seemed to be improving, the lights went out and he can tell us no more.

His physicians, however, take up the story, describing how, when first seen three years ago, he seemed to have simply a respiratory infection. This did not respond to antibiotics as it should have responded, and soon it became increasingly apparent that he was in what appeared to be congestive heart failure, with a blood pressure of 120 systolic, 90 diastolic, pulse 126 and regular, moderate enlargement of the heart to percussion and on fluoroscopy, and slight enlargement of the liver. As an explanation for these findings and for the heart failure,

a consulting internist suggested "a silent myocardial infarction."

Routine treatment for the failing heart, including rest, digitalis and diuretics, resulted in some improvement and enabled the patient to do light work over the next two years, but apparently only under medical supervision. Even then during the second year he had occasional relapses during which basal rales and ankle edema reappeared. During all this time there was progressive enlargement of the heart, and two months before his death a gallop rhythm, described as systolic, was first heard.

Two months later, in spite of treatment, he was so much worse that he was admitted to a hospital, apparently for the first time. His pulse was found to be 120 and regular, and a definite diastolic gallop rhythm was now described. Except for a slight elevation of temperature a few hours after admission, he was afebrile during a hospital course of one week. He improved greatly and, having lost 14 pounds, seemed better, when left hemiparesis and coma suddenly developed, and he was transferred to North Carolina Baptist Hospital.

Here he was found to be unconscious, responding only slightly to strong stimuli. The temperature was normal (100 F., probably rectal), respirations 24, blood pressure 120 systolic, 80 diastolic. On physical examination, recorded in the protocol, the heart was found to be enlarged 2 cm. lateral to the mid-clavicular line in the fifth interspace. A diastolic gallop rhythm was heard at the apex, but there were no murmurs. The liver and spleen are not mentioned. There was no peripheral edema, and nothing is said about the presence or absence of sacral edema.

On the second day it was thought for a time that he was a little better; he seemed to respond to slighter stimuli and even tried to say a few words. But then he became progressively febrile and worse, until his fever reached 105 F. on the fifth day and he died quietly with Cheyne-Stokes respiration and marked tachycardia.

Accessory laboratory data are relatively meagre. Early in his illness, fluoroscopy is reported to have shown cardiac enlargement. If other roentgen studies were done, they are not mentioned. All other laboratory data are those of his last hospital admission.

Urinalysis and blood counts were normal, with a later rise in the white cell count to 17,000 on the third day as the patient's temperature began to rise. The blood urea nitrogen was 22 and later 32 mg. per 100 cc. The total protein count was 7.2 Gm., with a normal albumin-globulin ratio. Chlorides, sodium and the carbon dioxide combining power were essentially normal, with possibly a slight acidosis. Potassium is not mentioned. Prothrombin and coagulation times were normal. The spinal fluid was clear and under normal pressure. The spinal fluid protein was 58 (possibly slightly elevated), sugar, 99; and the cell count was 11, including 10 red cells. Crenation is not mentioned.

Electrocardiograms are reported as showing sinus tachycardia and an occasional premature ventricular contraction, first degree heart block, with a slightly prolonged P-R interval and left axis deviation. Other findings which might be mentioned are a QRS amplitude of the limb leads within the lower limits of normal, a QRS interval at the upper limit of normal, deep Q waves and deep S4, and high R 5-6—findings which might be compatible with left ventricular hypertrophy, early intraventricular block, and myocardial damage, particularly in the region of the septum and conduction system.

Thus we see a man who, with no previous illness, manifested signs compatible with congestive heart failure associated with an enlarged heart without murmurs. In spite of treatment these symptoms progress inexorably, with increasing heart failure and cardiac enlargement, over the course of three and a half years, until admission to a hospital becomes necessary. During his hospital course left-sided hemiplegia suddenly develops, and after five or six days, he dies with high fever, Cheyne-Stokes respiration, and tachycardia.

During all this time, until the terminal phase, no mention is made of pain, cyanosis, significant fever, weight loss, or other evidence of illness, save that relating to his heart and what is apparently heart failure.

What could cause such a chain of events? Although this is a heart symposium, let us first consider extracardiac illness which might conceivably result in this picture, considering, first, metabolic and, second, pulmonary disease.

Among the general metabolic illnesses are some which I shall mention briefly only to discard.

Primary systemic amyloidosis is associated with cardiac involvement in 80 per cent of the cases, with congestive heart failure in 50 per cent and death from heart failure in 40 per cent of the cases. Nonspecific electrocardiographic changes, low voltage T wave changes and conduction defects may be present, and cardiac enlargement may be noted. These changes, however, are usually associated with other signs of amyloid disease throughout the body—lymph node involvement, and so forth—and the cardiac enlargement is not apt to be as great nor as progressive as in our case.

Secondary amyloidosis is associated with evidence of chronic disease or infection, and usually with albuminuria. Since primary cardiac amyloidosis is localized in the heart and usually occurs in people of advanced age—almost always over 70—I think this diagnosis may be discarded.

Glycogenosis of the heart is a disease of infants who rarely survive the first year of life. Rarely glycogen disease in adults occurs as a vague entity, but there is nothing in this case to suggest it. Lipochondrodystrophy, or gargoylism, is associated with dwarfism accompanied by many other deformities, together with valvular involvement and a failure to survive long after early youth. Hemochromatosis is usually associated with bronze diabetes, multiple transfusions or some other metabolic disorder and with other evidence of liver disease. Sarcoidosis need not, I think, be seriously considered, nor lupus, scleroderma, sickle cell anemia, so-called adiposity of the heart, and other rare conditions at times associated with cardiomegaly.

Beri-beri heart disease should be mentioned. There is no history of alcoholism or malnutrition in this patient, and no indication of improvement on a controlled diet. There are no signs of peripheral neuritis or pellagra, as the patient's blood count and total protein were normal. Neither is there evidence of the high output type of failure, of peripheral vasodilation with increased pulse pressure, or of accumulation of fluids in other serous cavities such as might suggest beri-beri.

Thyroid heart disease should always be considered in unexplained heart failure. This condition, like beri-beri and other types of curable heart disease, is one that we should always try to recognize, since cure is to be preferred to management, particularly in heart disease.

Thyroid heart disease can also be mentioned only to be discarded in this instance, however. Except for tachycardia, noted each of the few times the heart rate is mentioned (and these during episodes of failure), there is really no characteristic sign of hyperthyroidism in this patient or in his heart. Auricular fibrillation, often associated with hyperthyroidism, did not develop. Hypothyroidism amounting to myxedema may result in cardiac enlargement, low QRS complexes (usually even lower than in our patient), and in heart failure; but again there is no evidence even suggestive of myxedema. I shall not labor this point further, just as I shall not expand on the heart failure associated with secondary cardiac enlargement, sometimes seen in Paget's osteitis, cirrhosis of the liver, atrioventricular fistula, and other conditions.

Aside from these metabolic possibilities, we should mention the fact that chronic pulmonary disease such as emphysema or the generalized pulmonary infiltration that occurs in silicosis, berylliosis, some chronic infectious diseases of the lung, or diffuse infiltration of the lung by certain types of pulmonary tumors might result in secondary cardiac hypertrophy and failure. In such instances, however, there should be evidence of cor pulmonale with right axis deviation, and there should be more evidence of the primary lung disease than this patient presents.

Similarly, one should never forget the possibility of chronic, recurrent multiple pulmonary embolism as a cause of what appears to be heart disease and heart failure. Again, in this patient there is no evidence of right-sided heart strain, either chronic or acute, and there are no past symptoms which would lead one to suspect pulmonary emboli or a source of chronic pulmonary embolism either in the heart or periphery. Consequently, this diagnosis, too, must be discarded. And so I must conclude that the primary illness in this pa-

tient is neither a generalized metabolic disease nor a chronic pulmonary disease.

But now let us turn to the heart itself and try to discover why, in a healthy and relatively young man, this vital organ should have become enlarged and in the process should have produced a train of symptoms over three and one-half years which we must accept, as they are described in this protocol, as evidence of an inefficient, failing myocardium, with resulting congestive failure.

Could disease of the pericardium cause this picture? Indeed, disease of the pericardium can cause heart failure, but I doubt if it did so here. Constrictive pericarditis results usually, though not always, in a small quiet heart; and there are other characteristics which rule it out here. Certain types of adhesive pericarditis that do not produce generalized constriction may result in enlargement of certain cardiac chambers, depending on the in-flow or the out-flow tract or other area involved by the adhesions. But such general cardiac enlargement as this apparently was, and the clinical course which this case followed, would be unlikely.

Inflammation of the pericardium, effusions within the pericardium, tumors of the pericardium—none are really suggested here.

I do recall one case of apparently progressive cardiac enlargement over many years which eventually proved to be due to a large, diffuse benign tumor (as I recall, a lipoma) of the pericardium, but its course was relatively benign and I believe that it did not adversely affect cardiac function to any great degree.

Congenital heart disease is mentioned only to say that there is nothing to suggest it as a background for the development of the clinical picture seen in this patient at his age.

Valvular heart disease, when so far as we know no cardiac murmurs were heard at any time over a period of three years, must be dismissed for lack of evidence, though occasionally unsuspected valvular lesions are discovered in a heart where murmurs were thought to be absent or insignificant. Nor can subacute bacterial endocarditis be seriously entertained as a diagnosis in the absence of murmurs.

Infectious processes may involve the heart and result in so-called myocarditis and eventually in cardiac hypertrophy, dilatation, or both, with failure. But there is no evidence that present or past infection played a primary role in this case, and such a diagnosis would have to be made on microscopic rather than clinical grounds.

In this connection, it is well to note that the patient's serologic status, either for his blood or for his spinal fluid, is not reported in the abstract. We will recall that aneurysms of the ventricles occasionally give a false appearance of cardiac enlargement. Such aneurysms, however, usually are the result of previous myocardial infarction and are not, like aneurysms of the aorta, the result of syphilitic infection or of medial sclerosis.

Coronary heart disease is one of the chief causes of cardiac enlargement and heart failure, though the enlargement is more apt to be pronounced when associated with hypertension, which this patient apparently never had. It is to be recalled that an early consultant made a diagnosis of "a silent myocardial infarction," basing his conclusions on the electrocardiographic changes we already have described, plus the fact that something had apparently happened to this patient's heart. I believe that so-called "silent" coronary occlusions are the result of inattention on the part of some patients to their symptoms or of their inability to describe these symptoms accurately, or possibly of inattention on the part of doctors to details of the history. I cannot accept a diagnosis of coronary heart disease as the basis of progressive cardiac enlargement and failure over the course of several years without the patient's having at any time experienced subjective evidence of coronary insufficiency as manifested by angina of exertion or emotion, or by a recognizable episode of more severe ischemia or infarction.

Tumors, both metastatic and primary, malignant and benign, do indeed affect the heart and pericardium or any part of either, and may at times give rise to conduction defects, cardiac enlargement and failure, and other changes. Tumors within the heart usually are myxomas, and may simulate valvular disease and lead to cardiac enlargement. There are usually mur-

murs which change with position and possess other characteristics that make the diagnosis possible, particularly by visualization of the cardiac chambers. Lipomas, rhabdomyomas, sarcomas, endotheliomas, lymphoendotheliomas hemangiomas. and may affect various parts of the heart and conduction system but are unlikely to cause generalized enlargement. A primary malignant tumor of the heart itself is rare indeed. Three hundred cases are reported in the literature, and of these only 13 were diagnosed ante mortem. Nor is there anything here which would enable me to make a diagnosis of the fourteenth.

By now it would seem that we had exhausted all the probabilities without arriving at a diagnosis. We have not, however, except indirectly in mentioning tumors, myocarditis, metabolic disease and the like, considered the primary disease of the myocardium and endocardium itself as the cause of this syndrome.

There is a condition reported in this country as idiopathic cardiac hypertrophy which warrants our consideration. It was first reported in the French literature in 1901. Spodick and others, in 1958, found 72 acceptable cases in subsequent medical literature and added 8 cases of their own. The etiology of this group of cases is obscure, as the name would indicate. A background of nutritional deficiency is suggested because of certain similarities to the endocardial fibroelastosis reported as occurring on a deficiency basis in various groups of African natives, but this is only a hypothetical relationship. Similarly, fibroelastosis has been reported in infants and children, apparently on a congenital basis, possibly with a background of anoxia. It has also been described in adults.

This syndrome, as it is seen in adults, may prove to be simply a syndrome rather than a disease entity, as any idiopathic syndrome may prove to be. It usually occurs in the fourth and fifth decades, and is seen in both the Negro and white races, usually in men, usually laborers. The outstanding clinical features include progressive, intractable cardiac enlargement and failure, often with embolization, running a course of a month to years. Evidence of other disease usually is lacking, as is evidence of infection. Gallop rhythms, probably simply indicative of myocardial weak-

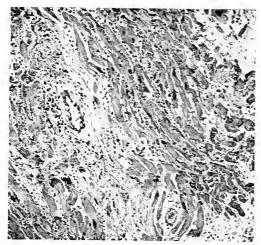


Figure 1

ness, are frequent, and are associated with signs of cardiac failure.

Electrocardiographic changes are nonspecific, with bundle branch block, prolongation of P-R interval, ST depression and T wave inversion, particularly in the lateral V leads, as was described in this case. The diagnosis must, to a large degree, be made by exclusion, as ours has had to be.

This, then, is my conclusion and my diagnosis: idiopathic cardiac hypertrophy with endomyocardial fibrosis. I would predict the following pathologic findings: first, in the brain an area of softening in the right hemisphere secondary to an embolus: second, in the lungs terminal broncho-pneumonia and probably small emboli as an incidental finding but possibly contributing to some of the episodes of recurrent failure. In addition, there should be severe passive congestion secondary to heart failure and probably terminal bilateral pleural effusion.

In the heart, I would expect hypertrophy to predominate over dilatation and to involve the left ventricle more than the right, and I would expect the heart to weigh between 550 and 650 Gm. The coronary vessels I would expect to be normal, as would be the valves and the pericardium. The endocardium should be the site of mural thrombi localized over areas of thickening and of fibrosis.

The myocardium I would expect to find rather firm but with an occasional hemorrhagic area. Microscopically, there should

be hypertrophy and degeneration and connective tissue proliferation, with numerous areas of interstitial and perivascular fibrosis, most marked in the endocardium and subendocardial layers, and possibly most marked, in this case, in the left ventricle and in the septum, involving the conduction system. There would probably be only small loci of secondary cellular reaction, without any evidence of a marked or active myocarditis. There might also be a thickened fibroelastic layer at the base of the endocardium. The remainder of the body I would expect to show only the changes secondary to cardiac failure such as liver engorgement.

Pathologic Discussion

DR. PRICHARD: Dr. Gilmour has come as close to the diagnosis as I would think humanly possible. I say "has come close to the diagnosis" advisedly, since when I tell you that our principal diagnosis was idiopathic myocarditis I have not said a great deal. The immediate cause of death was embolism of the right middle crebral artery, which had produced infarction of the right parietal and occipital lobes. The embolus had originated from a mural thrombus attached to the left ventricular wall. There were also infarcts in the kidneys and spleen. The heart was moderately enlarged (660 Gm.), markedly dilated, and without



Figure 2

valvular lesions or significant coronary artery disease. The other autopsy findings were nonspecific and noncontributory to this presentation.

Microscopically there were poorly outlined, small foci of coagulation necrosis of myocardial fibers, with moderate numbers of neutrophilic granulocytes and cardiac histiocytes interspersed with erythrocytes and prominent fibrocytes. In some foci there was a moderate amount of collagen deposition, and only a few of the cells mentioned above. The inflammatory process also involved the epicardium and endocardium to a minor degree, and one might properly refer to the entire process as pancarditis.

The subject of myocarditis is not a very satisfactory one for discussion, since very little is known about cases of the present type; probably due, in part at least, to their rarity. It is sometimes difficult to realize that it was not so very long ago that myocarditis was diagnosed with considerable frequency, largely because postmortem examinations were inadequate. Most of the "myocarditis" of years past would be recognized as myocardial infarction today.

There is much confusion over classification and terms in myocarditis, and to delve into this problem would be beyond the scope of this discussion. The excellent review of Saphir, a dissertation of 100 pages, examines the general question in great detail. There are recognized entities which produce myocarditis, rheumatic fever being the most common in all probability, and diphtheria serving as an example of infectious disease producing important degenerative and inflammatory changes in the myocardium. There is presumptive evidence which connects various drugs to myocarditis, and sulfanomides have been rather extensively belabored from this standpoint; in each instance there is a strong element of post hoc reasoning. After all conceivable etiologic agents have been eliminated, there remains a group of myocardial inflammatory lesions which have very little distinctive about them. Some occur in infants, and some in older people, like the present patient. I see no point in appending "Fiedler's" myocarditis to the diagnosis of this patient, since it adds nothing to our understanding of the disease, even if it does have a familiar ring. The significance of the rather vague respiratory illness which was a feature during this man's clinical course is unknown to me. It does not seem to have been severe enough to have an important relationship to his myocarditis, and there is a great deal of subjectivity in any evaluation of such ailments.

 Saphir, O: Myocarditis, Arch. Path. 32:1000-1051 (Dec.) 1941; 33:88-137 (Jan.) 1942.

Committees and Organizations

NORTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

The enlargement of programs to d al with chronic diseases tops the list of North Carolina's public health needs for 1960.

Compulsory immunization for poliomyelitis is viewed as the outstanding public health achievement of 1959.

During the first week of January Dr. J. W. R. Norton, State Health Director, took a look at problems and programs for the New Year as the staff of the State Board of Health reviewed achievements for the past twelve months.

The increasing industrialization of North Carolina has pointed up the presently inadequate facilities for occupational health services from the State Board of Health to the industries of North Carolina. The need for an enlargement of this service to the State is becoming increasingly recognized.

Passage by the 1959 General Assembly of compulsory immunization against poliomyelitis made North Carolina the first State in the Nation to enact this legislation, Dr. Norton stated.

Among other achievements of the past year were: the recognition by the General Assembly of the importance of the State Board's program of accident prevention; the extension of public health nursing services to the chronically ill in local health jurisdictions financially able to set up such a program; and the strengthening of the cooperation between the State Hospitals and the State Mental Health Authority.

Turning to newly emerging health problems and the longstanding needs in public health in North Carolina, Dr. Norton underlined the urgent need for the enlargement of the program of mental health services to families. Other newly emerging health problems in North Carolina which directly affect the citizens are noted as: staphylococcal infections occurring in nursing homes and hospitals, and the need for more adequate protection of private water supplies from chemical pollution. Migrant labor health problems and the extension of studies involving occupational hazards and involving alcoholism were also listed among the important emerging health problems. The study of atomic and nuclear programs as they affect

health administrative procedures will be important.

Longstanding public health problems challenging the State, as given by Dr. Norton included: expansion of chronic disease research work, health care of the aged, the great difficulty in recruitment and retention of qualified health personnel and the lack of adequate financial resources in all health areas at both state and local levels.

The increasing cost of medical care and hospitalization is seen as a problem both of long-standing and increasing importance. This increasing cost is resulting in inability of many families to obtain adequate health services.

North Carolina has created a demand for dental services which cannot be met promptly with present personnel and resources in either the field of private practice or public health. Dr. Norton stated

Shortages in personnel exist in all areas of health care. The state is thirty-ninth in the ratio of physicians to population and forty-second with respect to dentists The shortages are equally serious in public health personnel in all positions.

If adequate personnel and finances were available in North Carolina, the most important expansion in program, according to Dr. Norton, would be focused on protection and maintenance of adult health in an organized administered manner. This would form the basis of an added strengthening of the human and material resources and the total economy of the State, Dr. Norton stated.

"The State as a whole prospers, when, through good adult health, individuals and families and the communities prosper in ways that permit profitable and productive work," Dr. Norton concluded.

Classified Advertisements

WANTED: Male psychiatrist; Diplomate or with three years approved training; to join group practice 145-bed approved psychiatric hospital. Salary: \$15,000-\$18,000 first year; \$20,000-\$25,-000 second with incentive factor, Write Box 790 care this Journal, Raleigh, N. C.

ONE UROLOGICAL TABLE with x-ray equipment for sale. Write Douglas Hamer, Jr., M.D., Box 658, Lenoir, N. C.

GENERAL PRACTITIONER for agricultural and industrial supported rural community of eight thousand in Eastern North Carolina, L. A. Gardner, Chrm. Medical Service Committee, Sarataga Lions Club, Sarataga, N. C.

DESIRABLE LOCATION for a physician, Contact Godley Realty Company, Mt. Holly Road, Charlotte, North Carolina.

BULLETIN BOARD

COMING MEETINGS

Medical Society of the State of North Carolina, One Hundred Sixth Annual Session — Raleigh, April 8-11,

Greensboro Academy of Medicine-Greensboro, March 24.

Ninth Annual Cancer Symposium, sponsored by the Forsyth County Medical Society in cooperation with the Forsyth Cancer Service—Winston-Salem, March 31.

Eighth Annual North Carolina Hospital Food Service Institute—North Carolina State College, Raleigh, April 6-8.

First Physicians' Institute on Alcoholism—University of North Carolina School of Medicine, Chapel Hill, April 6 (2:00-6:00 p.m., followed by dinner and reception).

New Hanover County Medical Symposium— Cape Fear Country Club, Wilmington, April 8.

American College of Chest Physicians, Thirteenth Annual Postgraduate Course in Diseases of the Chest—Sheraton Hotel, Philadelphia, March 14-18.

American Academy of General Practice, Twelfth Annual Scientific Assembly—Philadelphia, March 21-24.

Chicago Committee on Trauma of the American College of Surgeons, Fourth Postgraduate Course on Fractures and Other Trauma—Chicago, April 27-30.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of January.

Dr. John W. Barnard, Banner Elk; Dr. Robert Clement Smith, Banner Elk; Dr. Jack Bernard Perkins, P. O. Box 1027, Southport; Dr. Claude Benjamin Goswick, Jr., 726 5th Avenue, W., Hendersonville; Dr. Arthur Sherman Morris, Jr., P. O. Box 25, Hot Springs; Dr. John F. Ditunno, Jr., Hot Springs.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Establishment of a new training and research program at Duke University to provide for effective collaboration between the social sciences and health fields has been announced by Dr. Paul M. Gross. vice-president in the Division of Education.

The program is headed jointly by Dr. John C. McKinney, chairman of the Department of Sociology, who has received the additional title of professor of medical sociology; and Dr. Ewald W. Busse, chairman of the Duke Medical Center's Psychiatry Department.

The appointment of Charles C. Boone as one of two assistant superintendents of Duke Hospital has been announced by hospital superintendent Charles H. Frenzel.

Succeeding the late Dewitt Wright, who died on August 10, 1959, Boone assumed his new position on January 26. He was formerly administrator of Barnwell County Hospital, South Carolina.

* * *

H. D. Maynard Jr. has been named assistant business manager of the surgical division of Duke Hospital's Private Diagnostic Clinic.

He will assume a position left vacant by Lewis W. Sykes, who has resigned effective December 31 to become business manager of the Miller Orthopedic Clinic in Charlotte.

A new clinic for children and young people afflicted with cystic fibrosis has been organized at the Duke University Medical Center.

Cystic fibrosis, a relatively common hereditary disease which affects the lungs and pancreas, has been recognized only within the past 20 years. Before the introduction of "miracle" antibiotics, few persons with the disease lived beyond 14 years of age.

The new Duke clinic is headed by Dr. Susan C. Dees, professor of pediatrics, and Dr. A. Douglas Rice, instructor in pediatrics. Working with them are other Duke pediatricians and members of the Medical Center's dietetics and physical therapy staffs.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Kenneth M. Brinkhous, professor and head of the Department of Pathology, is the editor of a new book concerning an international medical meeting held in Rome in September.

The book, entitled "Hemophilia and other Hemorrhagic States," has just been released by the

University of North Carolina Press.

The U.N.C. School of Medicine has long been known as one of the world's leading centers for the study of hemophilia and other bleeding diseases. The world's only colony of dogs that have hemophilia is located at the School of Medicine.

A capacity enrollment of 50 Tar Heel physicians attended a three-day course in pediatric cardiology at the University of North Carolina School of Medicine January 13-15.

Instructors for the course, in addition to a number of the faculty members of the U.N.C. School of Medicine, were Dr. Edward C. Lambert of the University of Buffalo School of Medicine and Dr. Robert F. Castle of the Duke University School of medicine.

Two leaves of absence and one appointment in the University of North Carolina School of Medicine have been announced by Chancellor William B. Aycock.

Dr. Charles H. Burnett, professor and head of the Department of Medicine, has been granted a one-year leave of absence beginning July 1. Dr. Burnett will be engaged in research in London at the University of London and the Galton Laboratory for Human Eugenics.

Dr. Carl W. Gottschalk will receive a year's leave at the same time. He will be engaged in research at the Biochemical Institute of the University of Copenhagen, Denmark,

Dr. A. J. Bambara has been appointed a U. S. Public Health Service practitioner trainee in the Department of Psychiatry.

A research grant in the amount of \$79,953 (for a three-year period) has been awarded by the National Institute of Mental Heath to Dr. Hans H. Strupp, associate professor of psychology and director of psychological services in the Department of Psychiatry. This research will concern the role and function of the psychotherapist's personality and attitudes in the psychotherapeutic process. The work has been in progress since 1955, and is carried out in collaboration with Joan V. Williams, Ph. D., and Martin S. Wallach, Ph. D.

The appointment of Rachel L. Nunley to the State Examining Committee of Physical Therapists was announced recently by Governor Hodges.

Miss Nunley, an instructor in physical therapy at the University of North Carolina School of Medicine, will serve a three-year term, succeeding Margaret Moore, chief physical therapist of the North Carolina Memorial Hospital.

North Carolina Memorial Hospital has been awarded a grant of \$114,494 by the General Medical Services Division of the National Institute of Health of the United States Public Health Service. The grant will finance a four-year research project entitled "Improving Hospital Physician Relations Through Education." Dr. Robert R. Cadmus, director of the Hospital and professor of hospital administration of the School of Medicine, will serve as principal investigator.

The purpose of this study is to develop with the existing medical curriculum an effective program of instruction which will provide to the maturing medical student a better understanding of the administrative implications of the practice of medicine, particularly in the hospital setting. It is hoped that with increased knowledge and with the development of sound and mutually acceptable concepts, these relationships can be strengthened on a national level.

Four women technicians in x-ray technology received certificates recently to mark the completion of a 15-month course in radiology sponsored by North Carolina Memorial Hospital.

The four are Nancy Lanier Green, Durham; Violet Sue Stancil, Kenly; Joyce Gayle Strickland, Wilmington; and Alice Louise Teague, Liberty.

University of North Carolina President William C. Friday was announced recently as a member of a special board to choose Markle Scholars—outstanding young doctors in medical schools in the United States and Canada.

The Markle Foundation of New York, which makes 25 awards a year of \$30,000 each to young physicians and surgeons, stated that President Friday will serve on the Markle Selections Committee for seven western states.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

A Department of Neurology has been established at Bowman Gray. Heretofore neurology has functioned as a section of the Department of Psychiatry. The Board of Trustees has approved Dr. Martin G Netsky, who has been in charge of the Neurology Section for the past four years, as chairman of the new department.

In establishing this new department, the Board of Trustees took note of the broad scientific and educational contributions and the growing importance of neurology in this institution. The staff of the Department of Neurology has participated in educational programs of undergraduate medical students in all four years, has developed strong programs at the graduate level in neurology and pediatric-neurology, and is now engaged in extensive and varied research activities.

Dr. Harold D. Green, professor of physiology and pharmacology, has been appointed to the editorial board of Circulation Research. This appointment is for a period of five years.

Dr. Samuel H. Love, instructor in microbiology and immunology, has returned after a year's leave of absence. During that time he was associated with the Department of Biochemistry at the University of Pennsylvania School of Medicine, where he was engaged in study of growth and cell differentiation from the biochemical viewpoint, utilizing tissue culture techniques.

The North Carolina Heart Association awarded Grants-in-Aid totaling \$9.132.00 to the following faculty members of the Bowman Gray School of Medicine: Drs. John LeMay, J. Maxwell Little, Jesse Meredith, Henry Miller, Joseph Whitley, and Nancy O'Neil Whitley.

FORSYTH COUNTY CANCER SYMPOSIUM

The ninth annual cancer symposium sponsored by the Forsyth County Medical Society and the Forsyth Cancer Service will be presented at the Hotel Robert E. Lee in Winston-Salem on March 31.

The following tentative program, entitled "Cancer in Childhood," has been arranged.

1:00 p.m.—Registration

1:15 p.m.—Symposium called to order Invocation—Dr. Mark Depp. Centenary Methodist Church Welcome—Dr. Charles R. Welfare, President Forsyth County Medical Society

Mrs. Fred P. Crouch, President Board of Directors Forsyth Cancer Service 1:30 p.m.—Basic biological features in childhood

cancer
Dr. James B. Arey. Associate Professor of Pathology, Temple Univer-

fessor of Pathology, Temple University, Pa. 2:00 p.m.—Childhood leukemia and related diseases

> Dr. Nathan J. Smith, Professor of Pediatrics, University of Wisconsin, Madison, Wisconsin

Medicine, will join the other speakers

Presiding-Dr. Charles R. Welfare

2:30 p.m.—Cancer of the genito-urinary tract in childhood Dr. Albert J. Paquin, Professor of Urology, University of Virginia,

Charlottesville, Va.

3:15 p.m.—Panel Discussion
Dr. Eben Alexander, Jr., professor of neurology. Bowman Gray School of

for this panel.
7:00 p.m. Dinner—Ballroom
Speaker: Dr. W. C. Davison

GREENSBORO ACADEMY OF MEDICINE

The following program has been arranged for the Greensboro Academy of Medicine to be held on Thursday, March 24.

"The Therapeutic Use of Radio Isotopes"— Manuel M. Garcia, M.D., Professor of Radiology, Tulane University School of Medicine, New Orleans

"Massive Hemorrhage From The Lower Gastrointestinal Tract: Diagnosis & Treatment"—Rudolf Noer, M.D., Professor of Surgery, University of Louisville, Louisville

"Perinatal Mortality"—D. Frank Kaltreider, M.D., Professor of Obstetrics. University of Maryland, Baltimore

"Congenital Heart Disease"—Allen Friedlich, M.D., Associate Professor of Medicine, Harvard Medical School, Boston

"Extent of Cancer Illness in the United States"

-Michael Shimkin, M.D., National Institute of Cancer, Bethesda, Maryland

"The Tired Mother Syndrome"—Leonard Lovshin, M.D. (after dinner), Cleveland Clinic, Cleveland, Ohio

NEW HANOVER MEDICAL SOCIETY

The New Hanover County Medical Symposium, held previously at Wrightsville Beach in July, will be presented this year on April 8 at the Cape Fear Country Club. The following program has been announced.

I-Panel Discussion on Tobacco and Cancer

1-Dr. Alton Ochsner-Surgeon in chief-Ochsner Clinic

2—Dr. Douglas Sprunt—Professor of Pathology—University of Tennessee

3—Representative from the Tobacco Industry
—Moderator Dr. George Lumb

II—Panel Discussion on Death and Its Legal

Consequences.
1—Dr. Milton Helpern—Chief Medical Ex-

aminer—New York City

2-Mr. Malcolm Seawell, Attorney General-State of North Carolina

3—Dr. Douglas Sprunt—Professor of Pathology—University of Tennessee Moderator, Mr. Aaron Goldberg

III-Panel Discussion on the Thyroid Gland

1—Dr. Milton Hamolsky, Assistant Professor of Medicine Harvard Medical School

2—Dr. R. M. Hill, Assistant Professor of Medicine, University of Alabama

3—Surgeon to be announced Moderator—Dr. Samuel Warshauer

ROBESON COUNTY MEDICAL SOCIETY

The Robeson County Medical Society held its monthly meeting on February 1 at Johnson's Restaurant in Lumberton. The program was sponsored by the Robeson County Unit of the American Cancer Society. Dr. Damon Blake, director of radiotherapy, Bowman Gray School of Medicine spoke on the use of cobalt therapy in the treatment of cancer.

The executive committee of the county unit of the American Cancer Society were guests of the society at the meeting.

FORSYTH COUNTY MEDICAL SOCIETY

The regular dinner meeting of the Forsyth County Medical Society was held on February 9 at the Hotel Robert E. Lee. Mr. C. W. Johnson, chief federal agent of the Narcotic Division, Greensboro, discussed the problem of narcotic addiction. A sound film was shown in connection with the discussion.

EDGECOMBE-NASH MEDICAL SOCIETY

The Edgecombe-Nash Medical Society met on January 13 at the Rio Restaurant in Rocky Mount. Dr. C. T. Smith was in charge of the program and introduced as speaker Dr. George Andrews of the Dorothea Dix Hospital, whose subject was preventive psychiatry.

Officers of the society for 1960 are as follows: Dr. J. G. Chamblee, president; Dr. O. E. Bell, president-elect; Dr. J. C. Brantley, Jr., first vice president; Dr. L. W. Robertson, second vice president; Dr. J. M. Warren, secretary and treasurer; Dr. N. B. Carter, editor of the Bulletin.

NEWS NOTES

Dr. Donald B. Koonce and Dr. John B. Codington of Wilmington have announced their association in the practice of general surgery, with offices at 408 Eleventh Street.

TRI-STATE MEDICAL ASSOCIATION

Annual Meeting, March 21 and 22, 1960, Columbia Hotel, Columbia, South Carolina.

Program

Monday, March 21

9:30 a.m.—"Current Medical Treatment of Hyper-Cholesterolemia and Hyperlipemia and Atherosclerosis"—Dr. Edwin Boyle, Jr., Charleston, S. C.

10:00 a.m.—Paper—"Recent Surgical Developments in Hypertension and Peptic Ulcer,"—Dr. Keith S. Grimson, Durham, N. C.

11:00 a.m.—Paper—"What Do Simple Kidney Function Tests Mean?"—Dr. Cheves McC. Smythe, Charleston, S. C.

11:30 a.m.—Paper—"Neurological Complications of Disease of the Cervical Spine,"— Dr. Rhett Talbert, Charleston, S. C.

12:00 Noon—Paper—"Diagnosis and Medical Management of Bleeding Esophageal Varices"—Dr. Malcolm P. Tyor, Durham, N. C.

12:30 to 2:00 p.m.—Luncheon Panel
Dr. Keith Grimson, Moderator, Dr.
Edwin Boyle, Jr., Dr. Cheves McC.
Smythe, Dr. Rhett Talbert, and Dr.
Malcolm P. Tyor

2:00 p.m.—Paper—"Pulmonary Alveolar Proteinosis"—Dr. William Schulze, Greenville, S. C.

2:30 p.m.—Paper—"The Role of Ascorbic Acid in Human Pathology"—Dr. Fred R. Klenner, Reidsville, N. C.

3:30 p.m.—Panel on Psychosomatic Medicine

(a) Dr. Charles Fulghum, Department
of Psychiatry and Neurology, Emory
University Medical College, Atlanta,
Georgia

(b) "How the Treatment of Some of Aged Psychotics Can be Effective"-Dr. James Asa Shield, Chief of Department of Psychiatry and Neurology, Medical College of Virginia, Richmond, Va.

(c) "Somatophysic Manifestations of Disease"-Dr. Vince Moseley, Chief of Department of Medicine, Medical College of South Carolina, Charleston.

(d) "Psychosomatic Problems in General Practice"-Dr. William Hendrix, President of S. C. Chapter of the American Academy of General Practice, Spartanburg, S. C. (e) General discussion by Drs. Fulghum, Shield, Moseley and Hendrix with questions from the floor.

Tuesday, March 22

8:30 a.m.-Paper-"Blood Sugar and Urine Sugar Determinations in the Diagnosis and Management of Diabetes"-Dr. William R. Jordan, Richmond, Va.

9:00 a.m.—Paper—"Office Urology"—Dr. Kenneth M. Lynch, Jr., Charleston, S. C.

9:30 a.m.-Paper-"Surgical Treatment of Facial Injuries"—Dr. C. C. Coleman, Jr., Charlottesville, Va.

10:00 a.m.-Paper-"Endocrine Therapy In General Practice"-Dr. J. Richard Sosnowski, Charleston, S. C.

11:00 a.m.-Paper-"The Treatment of Congestive Heart Failure"-Dr Paul D. Camp, Richmond, Va.

11:30 a.m.—Paper—"The Treatment of Electrolyte Emergencies"-Dr. Dana C. Mitchell, Jr., Columbia, S. C.

12:00 Noon-Paper-"Diagnostic and Treatment of Respiratory Infections in Children" -Dr. George Dean Johnson, Spartanburg, S. C.

12:30 to 2:00 p.m.-Luncheon-Panel Dr. C. C. Coleman, Jr., Moderator, Dr. Paul D. Camp, Dr. Kenneth M. Lynch, Jr., Dr. Dana C. Mitchell, Jr., Dr. George D. Johnson, Dr. J. Richard Sosnowski and Dr. William R. Jordan.

2:00 p.m.-Paper-"Problems in Immunization Against Infections Diseases"-Dr. Samuel F. Ravenel, Greensboro, N. C.

3:00 to 4:30 p.m.—Panel on Thyroid Disease (a) "Problems in Diagnosis and Treatment of Thyroid Disease"-Dr. William H. Prioleau, Moderator, Clinical Professor of Surgery, Medical College of S. C., Charleston, S. C. (b) "Medical Evaluation in Thyroid Disease"-Dr. Ben N. Miller, Senior

Visiting Staff, Internal Medicine. Columbia Hospital, Columbia, S. C. (c) "Pathological Pitfalls in the Diagnosis of Thyroid Lesions"-Dr. Rawling Pratt-Thomas, Professor of Pathology, Medical College of South Carolina. Charleston, S. C. (d) "Behavior of the Thyroid During Pregnancy"-Dr. Luther Talbert. Department of Obstetrics and Gynecology, University of North Carolina, Chapel Hill, N. C. (e) General Discussion by Drs. Priolear, Miller, Pratt-Thomas and Talbert with questions from the floor.

SOUTHERN MEDICAL ASSOCIATION

Robert F. Butts, Birmingham, business manager of Sonthern Medical Association, has been named executive secretary-treasurer of the 14.000-member association. He also retains his duties as business manager.

The announcement was made by Dr. Edwin Hugh Lawson, New Orleans, president of the S.M.A. following a meeting of the association's executive committee.

Dr. Lawson also announced the appointment of V. O. Foster, Birmingham, as professional relations counselor, C. P. Loranz, Birmingham, remains as adviser and special consultant, Dr. Lawson said.

Southern Medical maintains home office-headquarters at 2601 Highland Avenue, Birmingham. Its fifty-fourth annual meeting will be held in St. Lonis, Missonri, October 31-November 3 of this year.

SOUTHERN MEDICAL ASSOCIATION Section on Ophthalmology and Otolaryngology

At the meeting of the Sonthern Medical Association held in Atlanta on November 15-19, 1959, the following officers were elected for the Section on Ophthalmology and Otolaryngology for the coming year:

Chairman, Dr. George M. Haik, Professor and Head of the Department of Ophthalmology at Louisiana State University School of Medicine, 812 Maison Blanche Building, New Orleans 16, Louisiana.

Chairman-elect, Dr. Mercer G. Lynch, Assistant Professor of Otolaryngology, Tulane University School of Medicine, 3503 Prytania Street, New Orleans 15, Louisiana.

Vice-Chairman, Dr. Bernard J. McMahon, Director of the Department and Clinical Professor of Otolaryngology, St. Louis University School of Medicine, 8230 Forsythe Blvd., Clayton 24, Mis-

Secretary, Dr. Albert C. Esposito, First Huntington National Bank Building, Huntington, West Virginia, formerly instructor of ophthalmology, BULLETIN BOARD

Ohio State University College of Medicine, Columbus, Ohio.

The next meeting of the Section will be held in St. Louis, Missouri, from October 31 to November 3, 1960. Those interested in participating should write to the Secretary of the Section, Dr. Albert C. Esposito.

AMERICAN COLLEGE OF CHEST PHYSICIANS (SOUTHERN CHAPTER)

At the annual meeting of the Southern Chapter of the American College of Chest Physicians, held in Atlanta, Georgia, November 15-16, 1959, the following officers were elected: president—John H. Seabury, M.D., New Orleans, Louisiana; first vice-president—DeWitt C. Danghtry, M.D., Miami, Florida; second vice president—Henry R. Hoskins, D., San Antonio, Texas; secretary-treasurer—Joseph W. Peabody, Jr., M.D., Washington, D.C.

AMERICAN COLLEGE OF SURGEONS

A grant of \$146,275 by The John A. Hartford Foundation, Inc., of New York, to the American College of Surgeons to inaugurate a program for improving the medical management of the surgical and injured patient was announced recently Mr. Ralph W. Burger, president of the Foundation and Dr. I. S. Ravdin, chairman of the Board of Regents of the College.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Then next scheduled examinations (Part II), oral and clinical, for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from April 11 through 16. Formal notice of the exact time of each candidate's examination will be sent him in advance.

Candidates who participated in the Part I Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

The deadline date for the receipt of New and Reopened Applications for the '1961 examinations is August the first 1960. Candidates are urged to submit their applications as soon as possible before that time.

THE WORLD MEDICAL ASSOCIATION

The German Medical Association, host of the fourteenth General Assembly of the World Medical Association, scheduled to convene in West Berlin, September 15-22, 1960, has extended a cordial invitation to all the doctors of the world to attend this outstanding meeting.

Additional information including programs and schedules will be available on or about March 1 at the W.M.A. Headquarters Secretariat. Request should be addressed to: The World Medical Association, 10 Columbus Circle, New York 19, New York,

THE NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

More than 1,600,000 persons enrolled in the 73 Blue Shield Plans located in North America during the first nine months of 1959, and during the same period Blue Shield paid out over \$487,500,000 for medical-surgical care rendered to members, the National Association of Blue Shield Plans reported today.

The nationwide Blue Shield Plans and their sponsoring medical societies have registered outstanding progress in implementing the American Medical Association resolution—passed December 4, 1958—calling for the development of medical care coverage for the aged by voluntary means, John W. Castellucci, executive vice president of the National Association of Blue Shield Plans said recently in Chicago.

"We have just completed a special survey in order to determine the progress made by Blue Shield Plans since the passage of the AMA resolution last December 4 and the results are most encouraging," Castellucci reported.

"Only eight of the 67 Blue Shield Plans located in the United States, with only two per cent of total Blue Shield membership, have no programs for senior citizens in the works at the present time," he noted.

The Month in Washington

Overshadowing all other developments from the standpoint of the medical profession was the flat prediction from a high Administration official and key lawmakers that Congress this year would vote some sort of liberalization of the Social Security program.

There was general agreement that Congress would broaden the Social Security plan for permanently and totally disabled persons by removing the requirement that a person has to be at least 50 years of age before receiving such benefits.

However, there were forecasts of even further liberalization. House Speaker Sam Rayburn (D., Texas.) said monthly cash benefits also may be boosted. On the other hand, the House leader said he believed a majority of the House Ways and Means Committee were opposed to the disputed Forand bill that would finance partial health care for the elderly through higher Social Security taxes at an estimated extra cost of \$2 billion annually. As a result, he said, he did not think "there was a great deal of chance for it." But the AFL-CIO

From the Washington Office of the American Medical Association, 1523 L Street, N. W.

and some Congressional backers of the highly controversial bill were urging Congress to approve it this year.

Arthur S. Flemming, Secretary of Health, Education and Welfare, asserted that the Administration is planning to offer a program aimed at assisting needy aged to meet health bills, but gave no details. The official noted that the Administration has firmly opposed the Forand-type approach on grounds it would destroy the rapid progress in meeting the problem through private means. But Flemming, in a speech before the American Association of University Teachers of Insurance, said the Administration has an obligation "to stay with it" until it arrives at a plan.

Congress has extended the Social Security program every presidential election year since 1948, and 1960 appeared to be no exception. Whether or not the issue of

medical care for the aged will be included was one of the big question marks early in the session.

Shortly before Congress convened, the Boards of Trustees of the A.M.A. and the American Hospital Association, in a joint resolution, pledged to "mobilize their full resources to accelerate the development of adequately financed health care programs for needy persons—especially the aged needy—" at state and local levels

The Boards said Forand-type legislation is "not designed to assist to the needy, since they apply to all Social Security beneficiaries and exclude the majority of needy persons, who are not eligible for Social Security benefits."

Following the action, Dr. Louis M. Orr, A.M.A. President, and three other A.M.A. officials—Dr. E. Vincent Askey, President-Elect, Dr. F. J. L. Blasingame, Executive



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Vice President, and Dr. Ernest B. Howard, Assistant Executive Vice President—visited Vice President Richard M. Nixon at his Washington Office. They told the Vice President that by the end of this year an estimated 60 per cent of the nation's aged persons who want and need voluntary health insurance will have it.

Mr. Nixon, according to the officials, was delighted to receive the information and "very much interested" in the program of voluntary health insurance for the aged.

In Memoriam

Oscar Julian Houser, M.D.

WHEREAS, Dr. Oscar Julian Houser was born December 27, 1885, and died July 21, 1959.

He was educated in the schools of Gaston County and the North Carolina Medical College from which he graduated in 1914. He engaged in the general practice of medicine until 1921. He then took a graduate course in eye, ear, nose and throat at the Manhattan Hospital and the New York Postgraduate Clinic. He returned to Charlotte and followed this specialty until his death. During his span of life he gave wholeheartedly to his profession and to his church, and therefrom gained many firm and lasting friendships.

Therefore, be it Resolved, That the Mecklenburg County Medical Society has lost a valuable member and that he will be greatly missed by his colleagues; and that we, the members of the Mecklenburg County Medical Society express our deep sorrow and extend our sympathy to his bereaved family; and that a copy of these RESOLUTIONS be placed in the permanent files of this Society; and that a copy be sent to his family.

C. L. Nance, M.D., Chairman

H. L. Newton, M.D.

R. B. McKnight, M.D.



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Henry Lee Sloan 1886-1959

Henry Sloan was born in Ingold, North Carolina, August 6, 1886, the son of Dr. Henry and Catherine (Boykin) Sloan.

He attended the University of North Carolina, graduating with the degree of Bachelor of Arts in 1907, and received the degree of Doctor of Medicine from the University of Pennsylvania in 1911.

Postgraduate training was obtained at the Presbyterian Hospital in Philadelphia, Pennsylvania and at the New York Eye and Ear Infirmary.

He located in Lincolnton, North Carolina, where he practiced general medicine for one year and then became associated with the late Dr. J. P. Matheson and the late Dr. C. N. Peeler in the founding of the Charlotte Eye, Ear and Throat Hospital in 1923.

Dr. Sloan was a pioneer in ophthalmology in this area; and his interest, his enthusiasm, and his scientific achievement was widely acclaimed.

He maintained a keen interest in medical affairs, served as President of the Mecklenburg County Medical Society, was active in the affairs of the North Carolina State Medical Society, and received its Moore County Medal Award in 1926. He maintained an active interest in the American Academy of Ophthalmology and Otolaryngology and served on its regional committee for selection of candidates to the Society.

Dr. Sloan was married to Emily Patterson Elliott in 1919. Born to them were a daughter, Jane Elliott, now residing in Pittsburgh, Pennsylvania, and a son, Henry Lee Sloan Jr., an ophthalmologist associated with the Charlotte Eye, Ear and Throat Hospital. Emily died in 1947.

In 1951 he married Eleanor Clarke Bullard who survives him.

Henry Sloan was greatly endowed with charm and grace of manner which endeared him to a large circle of friends and confreres who were deeply sorrowed by his death November 5, 1959.

J. S. Gaul Joseph A. Elliott V. K. Hart

Dave Hebrank Smeltzer November 7, 1921—July 22, 1959

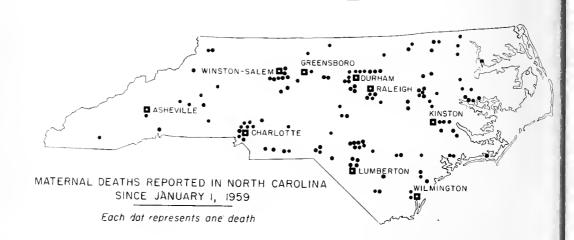
In the death of Dave H. Smeltzer on July 22, 1959, the Mecklenburg County Medical Society and citizens of our community lost a good friend, physician and loyal public servant.

Dr. Smeltzer was born November 7, 1921 in Youngstown, Ohio. He graduated from Rayen High School there in 1939, and received his A. B. degree from Duke University in 1943. His medical education was interrupted by four years of active duty with the United States Navy, following which he returned to Duke University and received his M.D. degree in 1950. From July, 1950-52 he served a rotating internship and rotating residency at Charlotte Memorial Hospital. Dr. Smeltzer entered general practice in August, 1952, with his office located at 3312 Tuckaseege Road. He had been in practice seven years at the time of his death. It is with regret that we mark the passing of this young physician and friend.

Dave is survived by one brother, his wife, the former Mildred James, and three children.

Be it therefore Resolved that a copy of this memorial be entered in the Minutes of the Mecklenburg County Medical Society, and copies be provided for his wife and his brother, Dr. James L. Smeltzer of Youngstown, Ohio, and the Medical Society of the State of North Carolina.

John M. Kester, M.D.





when you see signs of anxiety-tension specify

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You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. with relative safety: Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. 80:481 (Oct.) 1958.
2. Ferrand, P. T.: Minnesota Med. 41:853 (Dec.) 1958.
3. Mathews, F. P.: Am. J. Psychiat. 114:1034 (May) 1958.

SEARLE

properties



greater inhibitory action...lower intake per dose...Declomycin produces equivalent or greater clinical activity with less antibiotic because of two basic factors: (1) increased potency, and (2) longer retention.

broad-spectrum control in depth. Higher activity level enhances range of previous antibiotics. Some problem pathogens have been found more responsive. Strains of Pseudomonas, Proteus and A. aerogenes have proved sensitive to DECLOMYCIN.

sustained activity level. Declomyon maintains a more constant level of activity. Infection is quickly resolved.

24-48 hours extra activity...protection against relapse. Antimicrobial control is maintained after stopping dosage. Most other antibiotics dissipate rapidly on withdrawal.

REFERENCES:

1-11. Papers read at Seventh Symposium on Antibiotics, Washington, D. C., November 4-6, 1959.

12. Phillips, F. M.: DECLOMYCIN-Seventh Interim Report. Department of Clinical Investigation, Lederle Laboratories, Pearl River, N. Y., December 4, 1959.

CAPSULES, 150 mg., bottles of 16 and 100.

Oosage: average adult, 1 capsule four times daily.

PEGIATRIC DROPS 60 mg. (cg. in bottle of 10 cg. v.

PEOIATRIC DROPS, 60 mg./cc. in bottle of 10 cc. with calibrated dropper.

ORAL SUSPENSION, 75 mg./5 cc. tsp. in 2 oz. bottle.



a masterpiece of antibiotic design

performance

genitourinary infection. Roberts, M. S.; Seneca, H., and Lattimer, J. K., New York, N. Y.—Ninety-one percent of the Gram-positive and 27 per cent of the Gramnegative, among 66 organisms cultured from genitourinary infection, responded to DECLOMYCIN. Serum antibiotic activity was found three times greater than with tetracycline.

toleration. Boger, W. P., and Gavin, J. J., Norristown, Pennsylvania – Side effects with DECLOMYCIN were minimal. When dosage was 0.5 to 1 Gm. daily in divided doses, only two of 82 patients exhibited nausea.

activity level sustentation. Kunin, C. M.; Dornbush, A. C., and Finland, M., Boston, Massachusetts-Of the four tetracycline analogues, DECLOMYCIN Demethylchlortetracycline showed the longest sustained activity levels in the blood.

gonococcal infection. Marmell, M., and Prigot, A.,4 New York, N. Y. – Of 63 cases of gonorrhea, 61 promptly responded after short courses of DECLO-MYCIN. Therapeutic effect was found equal to that of intramuscular penicillin.

bronchopulmonary infection. Perry, D. M.; Hall, G. A., and Kirby, W. M. M., Seattle, Washington – Of 30 cases of acute bacterial pneumonia, all were afebrile following two to 10 days of treatment with DECLOMYCIN. Results were good in 21.... All of six patients with acute bronchitis responded promptly.

pediatric infection. Fujii, R.; Ichihashi, H.; Minamitani, M.; Konno, M., and Ishibashi, T., Tokyo, Japan – In 309 pediatric patients with various infections, DECLOMYCIN was effective in 75 per cent.

urogenital infection. Vineyard, J. P.; Hogan, J., and Sanford, J. P., Dallas, Texas – Clinical response in pyelonephritis correlated well with results of *in vitro* sensitivity tests, which showed some strains of A.



aerogenes, Proteus and Pseudomonas more susceptible to DECLOMYCIN Demethylchlortetracycline than to its analogues.

pneumonia. Duke, C. J.; Katz, S., and Donohoe, R. F., Washington, D. C. – Results were satisfactory in all but two of 32 cases of acute bacterial pneumonia, of which only 11 were uncomplicated. No side effects were observed.

brucellosis. Chávez Max G., Mexico, D. F., Mexico – All of nine patients with *Br. melitensis* infection were afebrile after five days on Declomycin. Blood cultures were negative in all cases on the 20th day. Side effects were limited to slight temperature increases which abated in four days.

pustular dermatosis. Blau, S., and Kanof, N. B., New York, N. Y. – Results with DECLOMYCIN were excellent in both of two cases of impetigo, one of two cases of folliculitis, six of nine cases of furunculosis, all of three cases of acne rosacea and 26 of 45 cases of acne vulgaris. Overall, results were excellent or good in 85 per cent.

antibacterial spectrum. Finland, M.; Hirsch, H. A., and Kunin, C. M.," Boston, Massachusetts—DECLOMYCIN Demethylchlortetracycline was found the most effective of the tetracycline analogues against two-thirds of 680 normally sensitive strains of 15 separate species.

the over-all picture. Combined results reported by 210 clinical investigators¹² – DECLOMYCIN produced a favorable response (cured or improved) in 87 per cent of 1,904 patients. Two-thirds of the patients received one capsule every six hours. Treatment was continued for as long as 180 days, but was between three and eight days in most. Side effects were seen in 9.9 per cent, but necessitated discontinuance of treatment in only 1.8 per cent.



Diagnostic Quandaries

Colitis? Gall Bladder Disease?
Chronic Appendicitis?

Rheumatoid Arthritis? Regional Enteritis?

DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.²

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.³

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of Simarouba glauca, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat

suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal ameliasis

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

- 1. Cook, J.E., Briggs, G.W., and Hindley, F.W.. Chronic Amebiasis and the Need for a Diagnostle Profile, Am. Pract. and Dig of Treat. &(1821 (Dec., 1955).
- 2 Rinebart, R.E., and Marcus, H. Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatold Arthritis, Northwest Med., 54:708 (July, 1955).
- Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. 9:897 (June, 1958).
- *U.S. Pat. No. 2,864,745

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Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

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Dehydrochloric Acid Compound, P-M Co. 265 mg. (Dehydrochloric Acid, 250 mg.); Homatropine methylbromide 1.2 mg.; Phenobarbital 8.0 mg.

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help restore the normal blood picture-iron as ferric pyrophosphate to restore or maintain normal hemoglobin.

boost appetite and energy-vitamins ... B1, B4 and B12.

upgrade low-grade protein-cereals and other low protein favorites of children, upgraded by I-Lysine, work with meat and other top protein to build stronger bodies.

tastes good! Each daily cherryflavored teaspoonful dose (5 cc.) contains:

I-Lysine HCI Vitamin B₁₂ Crystalline..... 25 mcgm. Thiamine HCI (B₁) 10 mg. Pyridoxine HCI (B₆)...... Ferric Pyrophosphate (Soluble) 250 mg. Iron (as Ferric Pyrophosphate) 30 mg. Sorbitol 3.5 Gm. 0.75%

Bottles of 4 and 16 fl. oz.

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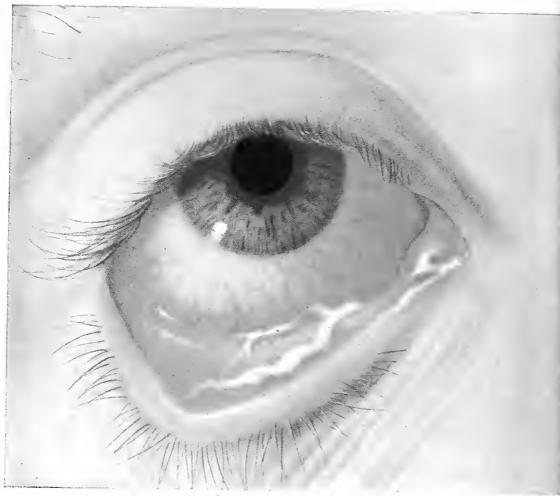
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1 Lippmann, O. Arch. Ophth. 57:339, March 1957. 2 Gordon, D.M. Am. J. Ophth. 46:740, November 1958. supplied 0.5% Sterile Ophthalmic Solution NEO.

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Shouldn't

KANTREX Injection'
be kept in reserve for
treating staph or gramnegative infections
until other antibiotics
have been tried first?



No. Naturally KANTEEN Injection should not be used in mild or self-limited infections, but as You states, "it ould not be withheld in moderately severe or severe infections."

Q What properties of Kantrex led Yow to draw this conclusion?

Next page, please

- Q What properties of Kantrex led Yow to draw this conclusion?
- a The following": (1) Kantrex Injection is bactericidal, not merely bacteriostatic; (2) it is absorbed rapidly after mtramuscular injection; (3) it has proved successful in many types of staph and gram-negative infections resistant to other antihiotics; and (4) it is well tolerated when used judiciously.
- Q But if I use Kantrex Injection, won't that help make bacteria resistant to it?
- A Numerous investigators have reported that micro-organisms do not readily develop resistance to Kanters in a clinical setting; and emergence of resistance to Kanters has not been a practical problem.
- Q How does the in vitro activity of Kantrex against staph compare with that of other antibiotics?
- a Griffith and Ostrander* tested 794 strains of staphylococci and found that 95.2% were sensitive to KANTEEX. By contrast, only 15.5% of the same organisms were sensitive to penicillin, 33.5% to tetracycline, 52.4% to erythromycin, and 71.7% to chloramphenicol.
- Q What about the sensitivity of other pathogens to Kantrex?
- a Leming "recently summarized the in vitro activity of Kantrex against 4493 strains of various organisms isolated from hospital patients over a 7-month period. He reported that the following percentages of these clinical isolates were sensitive to Kantrex: Proteus mirabilis, 98%; Proteus morganii, 94%; Proteus rettgen, 89%; Proteus vulgaris, 87%; Paracolobactrum intermedium, 96%; Coli-aerogenes group, 93%; Streptococcus viridans, 78%; Salmonella and Shigella, 92%.
- Q What do these figures mean clinically?
- A A great deal. As Yow stated in recent reviews of KANTREX Injection, it "appears to be one of the

most effective anti-staphylococcal antibiotics available today." ¹³ Kantrex Injection is also effective in the treatment of infections caused by "most strains of *E. coli, Proteus sp.*, the *Klebsiella pneumoniae-Aerobacter aerogenes* group, and many strains of *Pseudomonas aerugmosa* resistant to other antibiotics." In another report, Kantrex Injection was placed at the head of the list of drugs "with the most chance of success" against *A. aerogenes* minary tract infections."

- Q Have these findings about Kantrex therapy been substantiated by other investigators?
- d Yes, indeed, Finegold," who reviewed the clinical findings of 64 investigators, reported that infections which "usually responded" to Kantek included: staph infections (including staph enteritis), E. coli infections (including E. coli gastioenteritis), atypical acid-fast bacillus infections, Arobacter-Klebsiella infections, paracolon infections, Alcaligenes infections, Singella dysentery, Salmonella enteritis, anthrax, amebiasis, and E. histolytica carrier state. Among the infections that "sometimes responded" were listed: pneumococcal infections, group A beta-hemolytic streptococcic infections, Proteus infections, gonorrhea, and paratyphoid fever.
- Q. That's an impressive list, What didn't respond?
- a According to Finegold's tabulation, treatment failures were "usually" encountered in brucellosis, Pseudomonos infections, typhoid fever, mycotic infections and angember infections."
- Q How long do I have to give Kantrex Injection before I know whether it works or not?
- A Generally 2 or 3 days or less. Usually the effectiveness of Kantrex Injection can be determined in 24 to 36 hours. Rutenburg et al. reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."



anemycın sulfate injection (Bristol)

- Q How long should I continue to administer Kantrey?
- & If definite clinical response does not occur within 5 days, Kantrex therapy should be stopped and the antibiotic sensitivity of the invading organism rechecked.
-) What is the hazard of a patient developing hearing loss than 8 K NETTO X theraps '

In well hydrated patients with normal kidney function receiving Kantha Rail the recommended dosage schedule, the hazard of obtoxic reactions is negligible. In patients with impaired kidney function, the risk of obtoxic reactions is sharply increased, and in such case, the dosage should be reduced. Finegold has railed "Toxicity inherent in the drug can be avoided or immunized with cancial management."

nords road impairment influence the disage?

For my renal impurment delays the exerction of Foreign Enjoyen and causes an excessive concentration in blood and testics. Such excessive concentrations increase the risk of ototoxicity, Dosage recommendations emphasize that adequate serum levels can be achieved in such patients with a fraction of the dose suggested for patients with normal kidney function,

How con hart any reports of blood dysernsius?

None whatever.

- O You mean, then, that a physician who uses KANTBEX Injection judy worsty should find it not only effective but also well tolerated?
- Elfective? Certamly, against almost all staph or "gram-negatives," even though they may be resistant to other antibiotics. Well tolerated? Yes, when given in recommended disage. The physician can well agree with Yow, that while Kantrakx Injection should not be used in mild or self-limited infections, "it should not be withheld in moderately severe or severe infections." That, indeed, is the time to give it—first!

KANTREX CAPSULES

for local gastrointestinal therapy... not for systemic infections

- Q If Kantrex is not absorbed from the G.I. tract, what are the capsules used for?
- 8 Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.
- Q What types of intestinal infections, for instance?
- 2 Acute and chronic shigellosis, "a cute and chronic salmonellosis," in "a mebiasis," bacillary dysentery," infantile diarrhea, "" gastroenteritis," and staphylococcal enterocolitis."
- Q For preoperative bowel sterilization, why should I switch from neomycm to Kantrex Capsules?
- 2. Because Kantrex has been rated superior to neomycin for this purpose, 8 n n Out of 30 intestinal antiseptics studied, Kantrex was designated "the only single agent classified as a preferred drug," NANTREX "consistently eliminated all aerobic bacteria within 72 hours (and often within 24 to 36 hours) if a purgative was given with the first dose to expedite passage through the gastrointestinal tract."
- Q Is that all the advantage Kantrex has over neomycin for preoperative boisel sterilization?
- a Not at all, there are several others. Diarrhea, nausea and vomiting have not been observed with KANTEEX, though they occur frequently with neomycin; yeasts do not proliferate, in contrast to rapid growth with neomycin; and clostridia are well controlled with KANTEEX, and not controlled with neomycin." 21.25



INDICATIO

Infections due to kanamycin-sensitive organisms, particularly staph or gram negative ite urinary infections, skin, soft issue and post surgical infections conputation; tract :

DOSAGE INTRAMUSCULAR ROUTE

I small duly dose is 15 mg per kg of body weight, in 2 to 4 divided doses. See detailed mendations in insert accompanying each package 1

TOXICITY

When design recommendations are followed, the incidence of loss reactions to K tow. In well byforted patients indice 45 wers of age with normal kidney function, see a total due of 20 Gm or less of Kartina, the risk of severe obtains reactions as assent in patients with imparted react flactions or pre-receit automot. But daily does it Kartina for possibility of districtives in such patients with the reduced to avoid necumulation of the drug in section and tunner, thus our impossibility of districtives it wish patients of the theory is expected to leaf due autompted of multiple of such patients of additional principles of and during treatment. KARTINE, thereps was objected if multiple or subjected to have a manifematic patients.

OTHER ROUTES OF ADMINISTRATION

LANTII build be used by intravenius intuition only when the maramitectual maracticable. Kanties, can also be employed for interperitoneal size, nerosol frestrised in irrigating solution. See parkings insert for directions.

RECAUTIONS

I se of antibours may accumulatly result in overgrowth of non sensitive orgainfection appears during therapy, appropriate measures should be taken.

UPPLY

ninhle in rubber capped vials as a ready to use sterile aqueous solution in two

KANTREX injection, 0.5 Gm, kanomycin (as sulfote) in 2 ml. volume KANTREX injection, 1.0 Gm, kenumycin (as sulfote) in 3 ml. volume

CARSON IN THE COLUMN STREET COLUMN AND ASSESSMENT ASSESSMENT AND ASSESSMENT ASSESSM

INDICATIONS AND DOSAGE

For parameter was of sterilization 1.0 Gm 2 capacitast every hour for 4 hour old-111 Gm + apostosic every 6 hours for 36 to 22 hours for antisymptotic form. Adults 3.0 Lot 4.0 Gm (6 to 8 capacites) per day in do dec.

5 to colors. Intants and children 50 mg per kg per day in 4 to 6 divided doses in

eration of configurates Capaciles is contraindicated in the present

from Although only negligible amounts of Karriaca are absorbed through interminion the possibility of increased absorption from decreated or demaded areas about considered.

SUPPLY

KANTEEN Capsules, 0.5 Gm kanamycin (as sulfate) bottles of 20 and 100

REFERENCES

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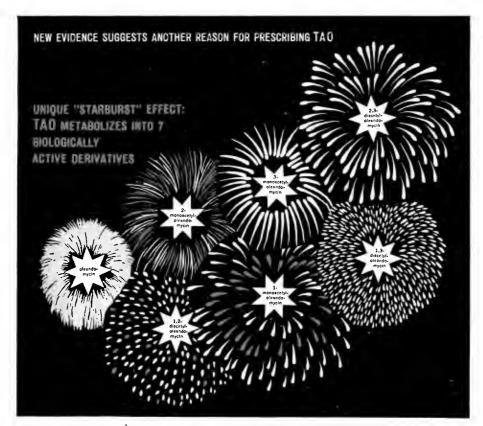


most effective anti-staphylococcal antibiotics available today." ^{1,2} Kantrex Injection is also effective in the treatment of infections caused by "most strains of *E. coli, Proteus sp.*, the *Klebsiella pneumoniae-Aerobacter aerogenes* group, and many strains of *Pseudomonas aeruginosa* resistant to other antibiotics." ² In another report, Kantrex Injection was placed at the head of the list of drugs "with the most chance of success" against *A. aerogenes* urinary tract infections.¹¹

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- a Generally 2 or 3 days or less. Usually the effectiveness of Kantrex Injection can be determined in 24 to 36 hours. Rutenburg et al. reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."¹³

- Q How long should I continue to administer Kantrex?
- a If definite clinical response does not occur within 5 days, Kantrex therapy should be stopped and the antibiotic sensitivity of the invading organism rechecked.
- Q What is the hazard of a patient developing hearing loss during Kantrex therapy?
- a In well hydrated patients with normal kidney function receiving Kantrex at the recommended dosage schedule, the hazard of ototoxic reactions is negligible. In patients with impaired kidney function, the risk of ototoxic reactions is sharply increased, and in such cases the dosage should be reduced. Finegold has stated: "Toxicity inherent in the drug can be avoided or minimized with careful management." 12
- Q Why should renal impairment influence the dosage?
- A Because renal impairment delays the excretion of Kantrex Injection and causes an excessive accumulation in blood and tissues. Such excessive concentrations increase the risk of ototoxicity. Dosage recommendations emphasize that adequate serum levels can be achieved in such patients with a fraction of the dose suggested for patients with normal kidney function.
- Q Have you had any reports of blood dyscrasias?
- a None whatever.
- Q You mean, then, that a physician who uses Kantrex Injection judiciously should find it not only effective but also well tolerated?
- a Effective? Certainly, against almost all staph or "gram-negatives," even though they may be resistant to other antibiotics. Well tolerated? Yes, when given in recommended dosage. The physician can well agree with Yow, that while Kantrex Injection should not be used in mild or self-limited infections, "it should not be withheld in moderately severe or severe infections." That, indeed, is the time to give it—first!





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English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100.880 (Apr.) 1959.
 Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277.
 English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.





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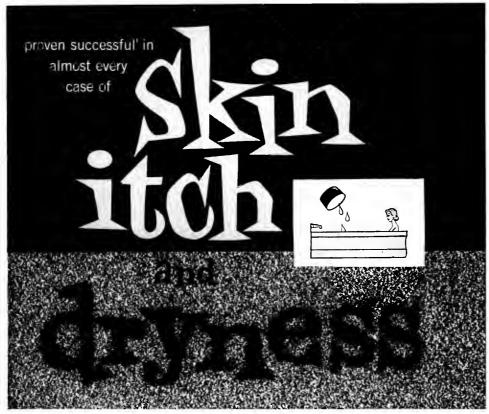
- 1. Fsbricant, N. D.: E.E.N.T. Montbly 37:460 (July) 1958. Lhotka, F. M.: Illinois M. J.: 112:259 (Dec.) 1957.
 Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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1. Spoor, H. J.: N. Y. State J. Med. Oct. 15, 1958

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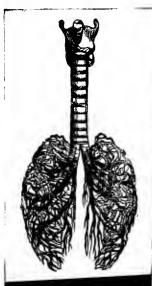
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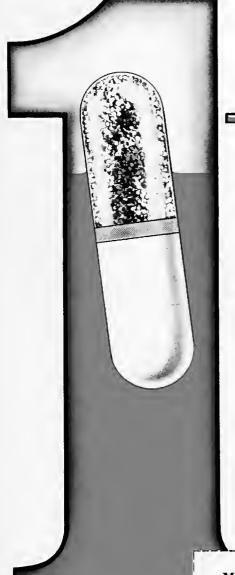
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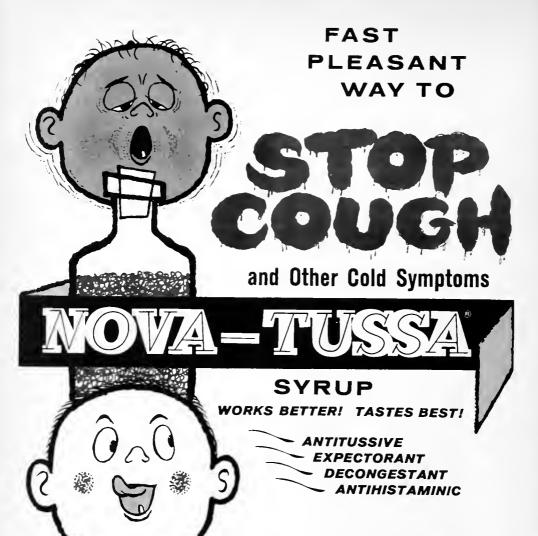
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in hacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among hacterial pneumonias, hased on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or grampositive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pnenmococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative Hemophilus influenzae and Klebsiella pneumoniae, Although K. pneumoniae causes only about 1 to 2 per cent of pnenmonia cases on the average,1 these are apt to be acute and fulminating (Friedländer's pnenmonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except by gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey? it was found that penicillin produced

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No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation, clinical observation and indepent of the physician.

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- a Some strains are not susceptible.
- b Table adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: 1. Wood, W. E., Jr.: In: A Textbook of Medicine, Edited by Cecil, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145, 2. Welch, H.; Lewis, C. H.; Weinstein, H. L. and Busekman, R. R.: Severe reactions to antibiotics. A nationwide surery, Antibiotic Med. & Clin. Ther. 4 and O (Dec.) 1955, 3. Keefer, C. S.: The choice of an anti-infective aceut. In: Drugs of Choice, 1988-1979. Edited by Walter Modell, St. Louis, The C. V. Moshy Co., 1988, p. 135,

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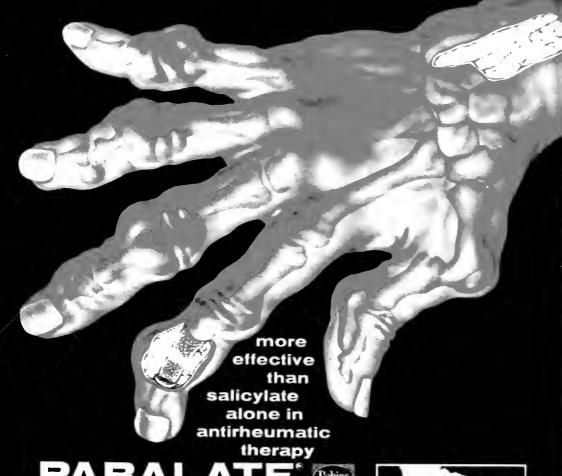
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1. Ford, R. A., and Flanchard, K.: Journal-Lancet 78:185, 1958.

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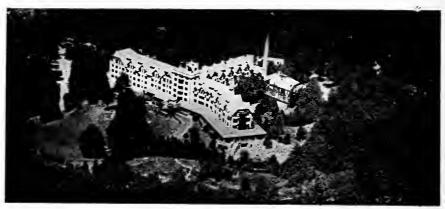
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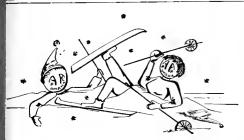
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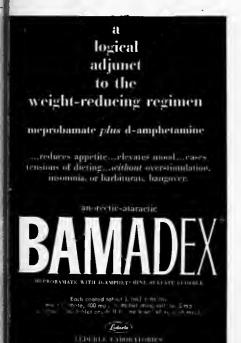
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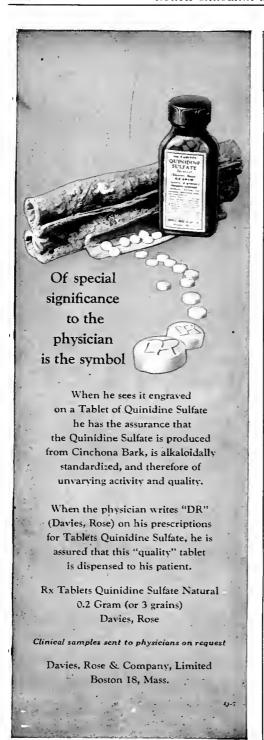
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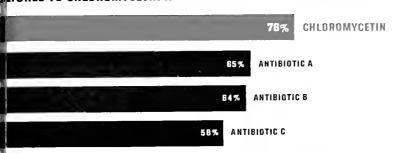
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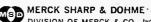


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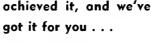
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1. Alexonder, L. (35 potients): Chemotherapy of depression — Use of meprobomote combined with benoctyzine (2-detehylomnachyl benzilate) hydrochloride. J A M.A. 106:1019, March 1, 1958. 2. Boteman, J. C. and Corlton, H. M. (50 potients). Meprobomote and benoctyzine hydrochloride (Deprol) os adjunctive theropy for potients with advonced concer. Antibiotic Med. & Clin. Theropy 0:648, Nov. 1959. 3. Bell, J. L., Touber, H., Sonly, A. and Pulito, F. (77 potients): Treofment of depressive stotes in aftice practice, Dis. Nerv. System 20:263, June 1959. 4. Breiner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:124, (Saction Two), May 1959. 5. McClure, C. W., Papos, P. N., Soere, G. S., Polmer, E., Slottery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceretia, G. 8. (128 patients): Treatment of depression—New technics and therapy. Am. Proct. & Digest Treat, 10:1255, Sept. 1959. 6. Pennington, V. M. (135 potients): Meprobomate-benactyzine (Deprol) in the treatment of chronic broin syndrome, schizophrenia and senitity. J. Am. Geriatrics Soc. 7:656, Aug. 1959. 7. Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. 8. Ruchwarqer, A. (87 potients): Use of Deprol (meprobomote combined with benactyzine hydrochloride) in the alfice treatment of depression. M. Ann. District of Columbia 24:338, Aug. 1959. 9. Settel, E. (52 potients): Treatment of depression in the elderly with o meprobomote-benactyzine hydrochloride, and 1959. 10. Spitter, S. R. (84 patients): The care of the anxious and the depressed. Submitted for publication, 1959.





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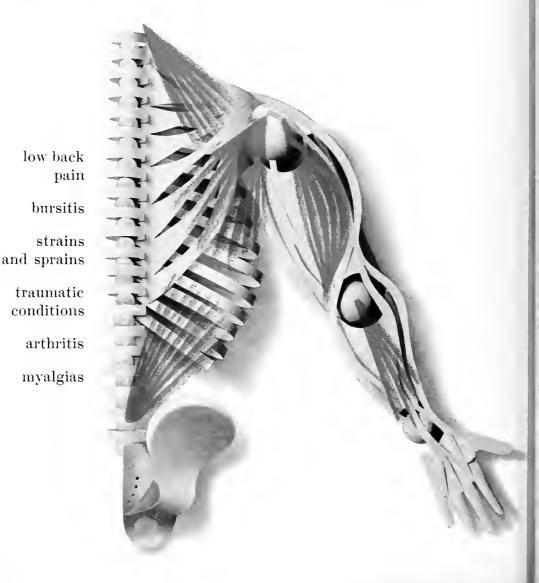
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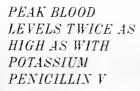
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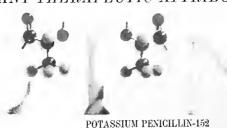


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The antibiotic effect of the clinically available mixture. SYNCILLIN. is greater than that of either of its two component isomers alone against many important pathogens. including some penicillinresistant staphylococci. This phenomenon has been described as Isomeric Complementarity.

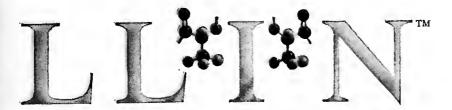
Significance of higher blood levels with SYNCILLIN Higher blood levels may be of value with organisms of only moderate penicillin sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition, these higher levels may be necessary where there is infection in areas with a poor blood supply. Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue. Also, antibiotic activity of SYNCILLIN is directly proportional to oral dosage. Increasing the dosage may, therefore, enhance the drug's effectiveness in certain cases.

Efficacy of SYNCILLIN against staphylococci and other resistant organisms Studies have shown that SYNCILLIN is effective in vitro against 60 to 75% of hospital "staph" strains, while penicillin G and penicillin V are now effective against only 30 to 50%. 1, 2 Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN would be expected to be the most effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal³ and gonococcal^{4,5} infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry



Relation of intermittent blood tevels YNCILLIN entibacterial

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle. "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective.... The therapeutic significance of this postpenicillin recovery period is enhanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process in vivo continues for many hours after the drug itself has fallen to ineffective concentrations."

Inced rate of inactivation YNCILLIN by staph penicillinase

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from B. cereus likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci. coryenbacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins. SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or sybhilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time itis not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins, Therefore, the usual precautions for oral penicillin therapy should always be observed. Patients with histories of asthma, hav fever, urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis. particularly in penicillin-sensitive individuals. Diarrhea has been reported

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

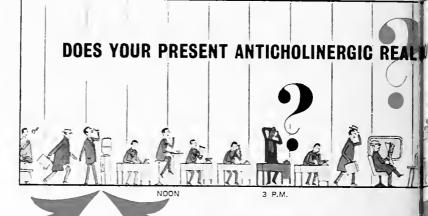
If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100, 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.:
Microbiology Report to Bristol
Laboratories Inc. 2. Marigi, E. M. E.;
Wheatley, W. B., and Albright, H.:
Paper presented at the Seventh Antibiotic
Symposium, November 4-6, 1959,
Washington, D.C. 3. Editorial: New
England J. Med. 261:305 (Aug. 6) 1959,
4. King, A.: Lancet 1:651 (Marth 29)
1958, 5. Epstein, E.: J.A.M.A. 169:1055
(March 7) 1959, 6. Eagle, H. and
Musselman, A. D.: J. Bact. 58:473, 1949



BRISTOL LABORATORIES, Division of Bristol-Myers Company, SYRACUSE, NEW YORK



The test—you might say the acid test—of an anticholinergic is simple: will it protect your patient from hyperacidity around the clock, even while he sleeps. The weakness of t.i.d. or q.i.d. preparations is well recognized; but even some "b.i.d." encapsulations may be unreliable. McHardy, for instance, found a "widely variable duration of action, definitely less than that anticipated" in the "sustained," "delayed," and "gradual release" anticholinergics he studied.

COMPARE THE DATA ON ENARAX . . . the new combination of an inherently long-acting anticholinergic (oxyphencyclimine) and Atarax, the non-secretory tranquilizer. Note the effectiveness of oxyphencyclimine:

OBSERVE THE OXYPHENCYCLIMINE REPORTS...

McHardy: "[Oxyphencyclimine] has proved to be an excellent sustainedaction anticholinergic in our study of this agent over a period of eighteen months."

Kemp: "... for the majority of patients, one tablet every 12 hours provided adequate control. This characteristic long action... may constitute an advantage of this drug as compared to coated 'long-acting' preparations of other compounds."

Add Atarax to this 12-hour anticholinergic. The resulting combination—ENARAX—now gives relief from emotional stress, in addition to a reduction of spasm and acid. Atarax does not stimulate gastric secretion. No serious adverse clinical reaction has ever been documented with Atarax.

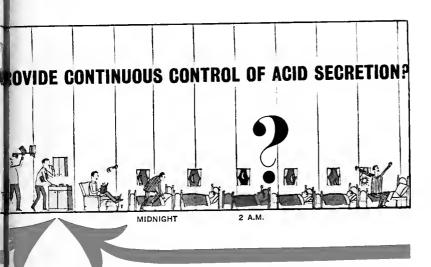
LOOK AT THE RESULTS WITH ENARAX4.5:

Does the medication you now prescribe assure you of all these benefits? If not, why not put your next patient with peptic ulcer or G.I. dysfunction on therapy that does.

ENARAX

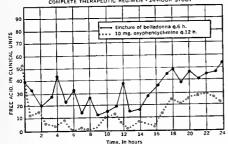
(axypheno) climine plus ATARAX3)

A SENTRY FOR THE G.I. TRACT



"Prolonged periods of achlorhydria" after 10 mg. oxyphencyclimine q. 12 h."

MEAN GRAPH OF GASTRIC ACIDITY IN 4 PATIENTS RECEIVING
COMPLETE THERAPEUTIC REGIMEN - 24-HOUR STUDY



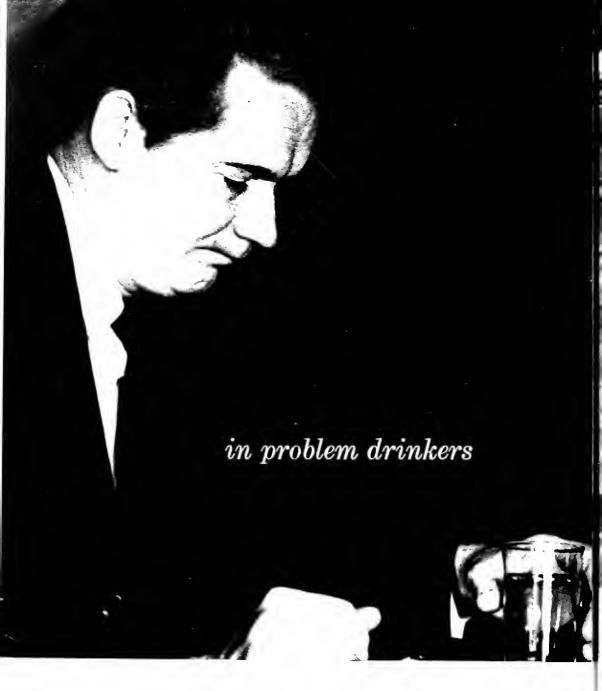
Clinical Diagnosis: Peptic Ulcer — Gastritis — Gastroenteritis — Colitis — Functional Bowel Syndrome — Duodenitis — Hiatus Hernia (symptomatic)—Irritable Bowel Syndrome — Pylorospasm — Cardiospasm — Biliary Tract Dysfunctions — and Dysmenorrhea.

Clinical Results: Effective in over 92% of cases.
As for Safety: "Side reactions were uncommon, usually no more than dryness of the mouth..."

Each ENARAX tablet contains:



New York 17, N. Y. Division, Chas. Pfizer & Co., Inc. Science for the World's Well-Being™



Vistaril

hvitroxvain, namoat,

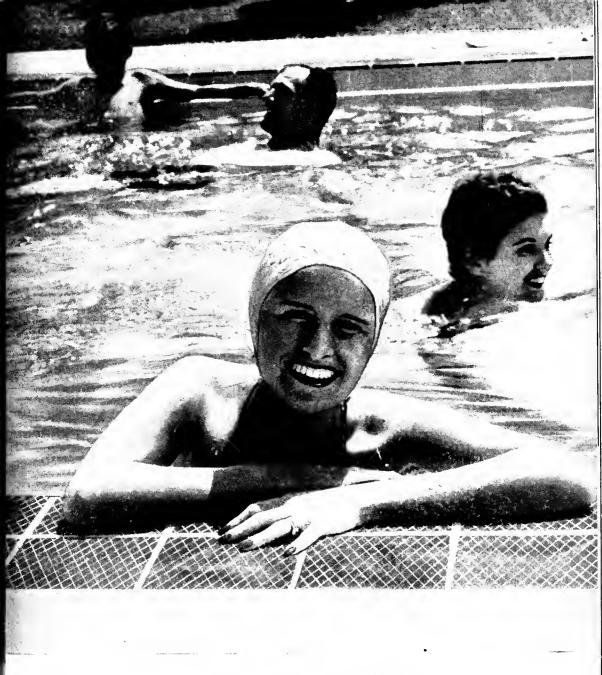
dispels tension...
maintains tranquility

When tension and anxiety "drive him to drink," the problem drinker often finds that VISTARIL, by maintaining tranquility, restores perspective and helps him accept counsel more readily.

VISTARIL has demonstrated a wide margin of safety even in large doses (300-400 mg. daily) over prolonged periods. Clinical studies of alcoholism have shown that VISTARIL produces no significant depression of blood pressure, pulse rate, or respiration in chronic drinkers.

Capsules-25, 50, and 100 mg. $Parenteral\ Solution$ (as the HCl)-25 mg. per cc., 10 cc. vials and 2 cc. Steraject§ Cartridges; 50 mg. per cc., 2 cc. ampules.





Of course, women like "Premarin"

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

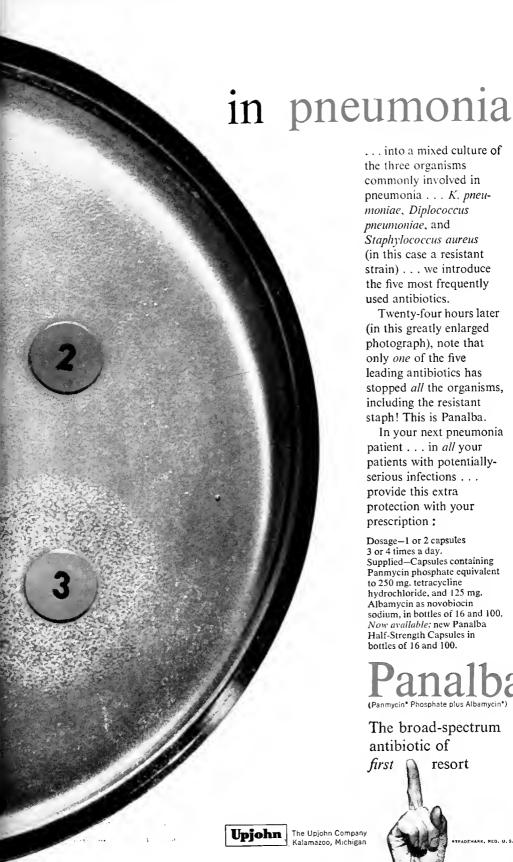
The patient isn't alone in her de-

votion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (cquine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone. Ayerst Laboratories * New York [16. N. Y. * Montreal, Canada [aprel]





... into a mixed culture of the three organisms commonly involved in pneumonia . . . K. pneumoniae, Diplococcus pneumoniae, and Staphylococcus aureus (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only one of the five leading antibiotics has stopped all the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in all your patients with potentiallyserious infections . . . provide this extra protection with your prescription:

Dosage-1 or 2 capsutes 3 or 4 times a day. Supplied-Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100. Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

The broad-spectrum antibiotic of first

resort

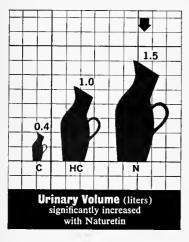
ADEMARK, REG. U. S. PAT. OPF.

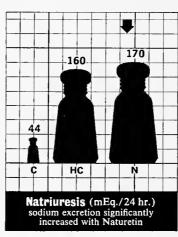
more closely approaches the ideal diuretic

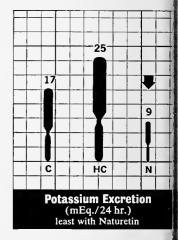
Naturetin Squibb Benzydroflumethiazide

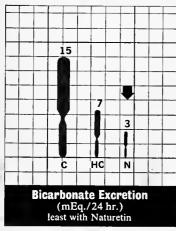
"When compared to other members of this heterocyclic gr of compounds, this drug [NATURETIN] shows a significantly creased natriuresis and decreased loss of potassium and bi bonate. In this respect it more closely approaches a natura 'ideal diuretic.' It is effective upon continuous administration causes no significant serum biochemical changes. It is effect in a wide variety of edematous and hypertensive states represents a significant advance in diuretic therapy." Ford, I Pharmacological observations on a more potent benzothiadia diuretic; accepted for publication by the American Heart Jour

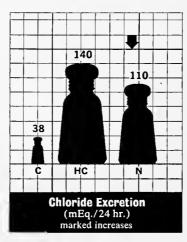
Comparison of electrolyte excretion pattern for the 24 hours following typical doses of chlorothiazide, hydrochlorothiazide, and Naturetin

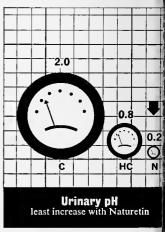












Typical Doses: Chlorothiazide -1,000 mg.; Hydrochlorothiazide -50 mg.; Naturetin (Benzydroflumethiazide) -5 mg

single 5 mg. tablet once a day rovides all these advantages²

prolonged action — in excess of 18 hours convenient once-a-day dosage

low daily dosage — more economical for the patient no significant alteration in normal electrolyte excretion pattern repetitively effective as a diuretic and antihypertensive greater potency mg. for mg.—more than 100 times as potent as chlorothiazide potency maintained with continued administration low toxicity — few side effects — low salt diets not necessary comparative studies with chlorothiazide, hydrochlorothiazide, and Naturetin disclose that smallest doses of Naturetin produce greater weight loss per day in hypertension, Naturetin, alone or in combination with other antihypertensives, produces significant decreases in mean blood pressure

purpura and agranulocytosis not observed

allergic reactions rarely observed

and other favorable clinical effects

²Reports (1959) to the Squibb Institute for Medical Research.

turetin —Indications: in control of edema when diuresis is required, in congestive heart failure, he premenstrual syndrome, nephrosis and nephritis, cirrhosis with ascites, edema induced by drugs rtain steroids); in the management of hypertension, used alone, combined with Raudixin (Squibb uwolfia Serpentina Whole Root), or with other antihypertensive drugs, such as ganglionic blocking agents.

ntraindications: none, except in complete renal shutdown.

cautions: when Naturetin is added to an antihypertensive regimen including hydralazine, atrum, and/or ganglionic blocking agents, immediate reduction must be made in the dosage for all parations; the dosage for ganglionic blocking agents must be decreased by 50% to avoid a precipitous p in blood pressure. This also applies if these hypotensive drugs are added to an established Naturetin imen . . . in hypochloremic alkalosis with or without hypokalemia . . . in cirrhotic patients or those on italis therapy when reductions in serum potassium are noted . . . in diabetic patients or those

italis therapy when reductions in serum potassium are noted . . . in diabetic patients or those disposed to diabetes . . . when increased uric acid concentrations are noted . . . when signs — or abdominal cramps, pruritus, paresthesia, rash—suggestive of hypersensitivity, are noted.

turētin — Dosage: in edema, average dose, 5 mg., once daily, preferably in the rning; to initiate therapy, up to 20 mg., once daily or in divided doses; for intenance, 2.5 to 5.0 mg., daily in a single dose. In hypertension: suggested tial dose, 5 to 20 mg. daily; for maintenance, 2.5 to 15 mg. daily, depending the individual response of the patient. When Naturetin is added to an anti-pertensive regimen with other agents, lower maintenance doses of each 18 should be used.

turetin - Supplied: tablets of 2.5 mg. and 5 mg. (scored).

Squibb Squibb Quality the Priceless Ingredient

Sig- pach



When you want to prescribe a regimen to reduce serum cholesterol and beta lipoproteins, are drastic diet changes necessary?



Fortunately, no. Often only two steps

- are necessary: (1) control of the amount of calories and of dietary fat, and
 - (2) a simple modification of food preparation method in which poly-unsaturated vegetable oil is used in place of saturated fats.

Obviously, in any special diet, the fewer required changes in the patient's eating habits, the more likelihood there is that the patient will adhere to the prescribed diet.

Once total fat and calorie intake is adjusted, the simple replacement of saturated fats, used at the table and in cooking, with poly-unsaturated Wesson makes possible a most subtle dietary change, yet conforms completely to therapeutic requirements.

Where a vegetable (salad) oil is medically recommended as part of a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

Uniformity you can depend on. Wesson has a polyunsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.



Wesson satisfies the most exacting appetites. To be effective, a diet must be eaten by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Wesson's Important Constituents

Never hydrogenoted—completely salt free

Each pint of Wesson contains 437-524 Int.

Units of Vitamin E.

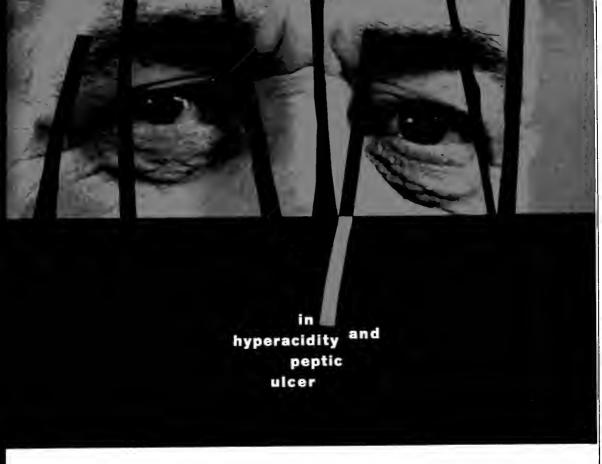
anxiety pushing it up?



SERPASIL makes it go down!

2/2767 MB

C I B A



as reactive in tablet form . . .

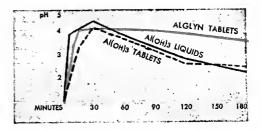
ALGI

Dihydroxy aluminum aminoacetate

The superiority of Alglyn (dihydroxy aluminum amino-acetate) as an antacid over ordinary aluminum preparations is quite pronounced. Not only do Alglyn Tablets act as rapidly as aluminum hydroxide gels and magmas, but they maintain a much more effective pH for a longer time (see chart).

Furthermore, Alglyn Tablets are decidedly superior when antacid-belladonna therapy is indicated. Ordinary aluminum preparations may actually adsorb as much as 80% of the spasmolytic drug, as compared to only 7% for Alglyn Tablets. In addition, Alglyn contains no sodium and less aluminum.

Supplied in bottles of 100 0.5 Gm. tablets. Also as Belglyn® (with belladonna), and as Malglyn® (with belladonna and phenobarbital). Literature available upon request.







bring all of her concepts of cleansing

Many women don't know that a vinegar douche is as old-fashioned as the copper tub, a relic of an empiric age.\(^1\) Acids actually make mucus discharge more tenacious. On the other hand, soaps and harsh alkali are irritating. A detergent douche — TRICHOTINE, the only major douche containing sodium lauryl sulfate — is the modern, more

efficient yet gentler vaginal irrigant.

The detergent action of TRICHOTINE assures greater penetration of viscid mucus, better dispersion of the healing medicaments on the mucosal surface, and more efficient removal of vaginal discharge.

If there is any doubt in your mind, compare TRICHOTINE with vinegar or any other

Goodman, L.S. and Gilman, A.: The Pharmacologic Basis of Therapeutics, MacMillan, 1955.



...up to date with TRICHOTINE

solution in your office clean-up. You will see readily the advantages of TRICHOTINE. It will prove equally desirable for home douching.

The pH changes produced by any low pH douche last only a few minutes² and are of questionable value in healing.³ TRICHOTINE actually favors epithelial growth and

healing,³ assures maximum cleansing, soothes inflamed mucus membranes.

TRICHOTINE is indicated in the management and treatment of cervicovaginitis and leukorrheas, alone or in conjunction with other antimicrobials. TRICHOTINE is ideal for routine feminine hygiene — safe, gentle and effective.

The Fesler Company, Inc.
375 Fairfield Avenue, Stamford, Compositent

Karnaky, K.J.: J.A.M.A. 157:1155, 1955 (August)
 Scheinberg et al: Surgery 24:972, 1948 (Dec.)





eases mental adjustment to menopause

NIAMID brightens the outlook of depressed menopausal patients — gradually helps them become alert, cheerful, relaxed, and better able to cope with their surroundings.

Start with 75 to 100 mg. of NIAMID daily and adjust according to response. In routine use, up to 200 mg. is given. The gradual response to NIAMID may be noted within several days or weeks.

Infrequent, mild side effects may occur but often are lessened or eliminated by dosage reduction. NIAMID has not been reported to cause jaundice, disturbances of color vision, ankle edema, or skin eruptions.

NIAMID (brand of nialamide) is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already prescribed for more than 500,000 patients.

A Professional Information Booklet is available on request from the Medical Department, Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.



Science for the world's well-being "

Today-as before-

Only Kent offers this remarkable combination:

FINEST NATURAL TOBACCOS FAMOUS MICRONITE FILTER

Millions of smokers have changed to Kent because of this combination. They discovered that this combination was the reason why Kent satisfies your appetite for a real good smoke.

First, finest natural tobaccos. Kent uses only the finest natural tobaccos—ripe, golden leaves—which, when shredded into tiny strands and carefully blended, produce a real tobacco taste.

Second, Kent's famous Micronite filter which contains a remarkable series of flavor channels. The rich taste of natural tobaccos flows through with a free and easy draw. The Kent filter is not too long, not too short, not too tight—

smokers get every delicate shading of flavor of Kent's finest natural tobaccos.

Others may imitate, but none can duplicate the quality of Kent.

If you would like the booklet for your own use, "The Story of Kent," write to: P. Lorillard Company Research Department 200 East 42nd Street New York 17, N. Y.

© 1960, P. Lorillard Co.



Today—as before—for good smoking taste, it makes good sense to smoke Kent, because Kent satisfies your appetite for a real good smoke.

A Product of P. Lorillard Company-First with the finest cigarettes-through Lorillard Research!

Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions.

It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths -

PHENAPHEN NO. 2

Phenaphen with Codeine Phosphate 1/4 gr. (16.2 mg.)

PHENAPHEN NO. 3

Phenaphen with Codeine Phosphate 1/2 gr. (32.4 mg.)

PHENAPHEN NO. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also -

PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. (162 mg.)
Phenacetin 3 gr. (194 mg.)
Phenobarbital ½ gr. (16.2 mg.)
Hyoscyamine sulfate (0.031 mg.)

PHENAPHEN® WITH CODEINE Robins



A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

Trilafon for the anxiety in the person overwhelmed by family illness... selective anxiety relief with minimal drowsiness or dulling



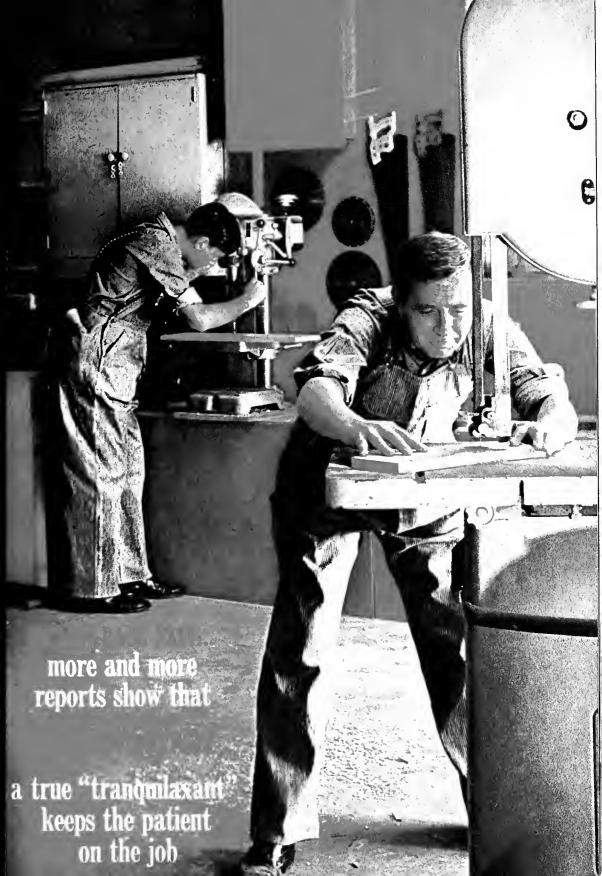


the clock strikes Z and your ulcer patient sleeps undisturbed

daricon

 $2^{tablets\ daily-'round-the-clock\ relief}$ from ulcer and other GI disorders.

Additional information is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, New York. Pfizer Science for the world's well-being.



relieves painful muscle spasm and relaxes the patient



Impressive numbers of patients with low back pain and other musculospastic conditions treated with Trancopal have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports. In a recent study by Lichtman, Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases), and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Lichtman comments: 66 Chlormethazanone [Trancopal] not only relieved painful muscle spasm, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks, 992

When you prescribe Trancopal for musculoskeletal disorders, you can confidently expect that your patients will be relieved of the pain and stiffness. You can be sure of their speedy return to everyday work and recreation.

Mullin and Epifano call Trancopal ...a very effective skeletal muscle spasmolytic. Phey found that Trancopal brought good to excellent relief to all of 39 patients with skeletal muscle spasm related to trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome. (No side effects were noted except that one patient had slight lryness of the mouth.)

The pattern is similar in every new series reported: Ganz, DeNyse, Shanaphy and Stough.

Trancopal is a true "tranquilaxant"

Francopal "...combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."

Relieves dysmenorrhea



Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort. Shanaphy suggests that Trancopal may help the patient by its combination of muscle relaxant and tranquilizing actions, and he finds that 66... the continued use of chlormezanone [Trancopal] as a therapeutic agent in dysmenorrhea is advisable. Trancopal was effective in 82 per cent of his series of 50 patients. In another study, which dealt with 52 adolescent girls and 23 women, Stough reported that Trancopal gave complete or moderate relief in 86.4 per cent.

Alleviates tension

And, of course, Trancopal is also very useful in the treatment of patients in anxiety and tension states. As Ganz says, 66... a most valuable drug for relieving tension, apprehension and various psychogenic states... allows the patient to use his energies in a more productive manner in overcoming his basic problems. ?? 4

Trancopal

a true "tranquilaxant"

that relieves skeletal muscle spasm and relaxes psychogenic tension without troublesome side effects. and keeps the patient on the job.

Indicated for...

Musculoskeletal disorders

Psychogenic disorders

Low back pain (lumbago) Neck pain (torticollis) Bursitis

Rheumatoid arthritis Osteoarthritis Disc syndrome

Fibrositis Ankle sprain, tennis elbow Myositis

Postoperative muscle spasm Anxiety and tension states Dysmenorrhea Premenstrual tension Asthma

Angina pectoris Alcoholism

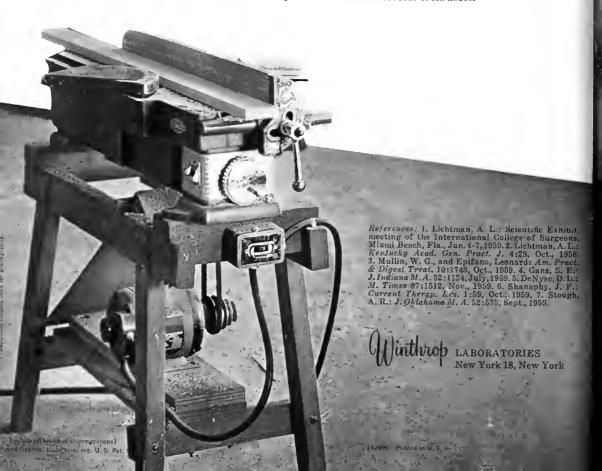
Now available in two strengths:

Trancopal Caplets®, 100 mg. (peach colored, scored), bottles of 100.

STRENGTH

Trancopal Caplets, 200 mg. (green colored, scored), hottles of 100.

 $Dosage: {\it Adults}, 100~{\rm or}~200~{\rm mg.}~{\rm orally~three}~{\rm or~four~times~daily}.~{\it Relief~of~symptoms}~{\rm occurs~in~from~fifteen~to~thirty~minutes~and~lasts~from~four~to~six~hours}.$



it started as a "cold"...

to prevent
the sequelae
of u.r.i....
and relieve the
symptom complex

ACHROCIDIN*

Tetracycline-Antihistamino-Analgesic Compound La ferla

Sinusitis, otitis, tunsillitis, adenitis, bronchitis or pneumonitis develops as a serious fracterial complication in about one in cight cases of acute upper respiratory infection. (9) To protect and relieve the "cold" patient ... ACHROCIOIN.

Usual diseage: 2 tel·luts or teasp-ornfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET ornteins: ACHKOMYCIN* Tetracycline HC1 (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUF, caffeine-free.

Estimain foscil in epiriumini de study by Ven Vilkentungh,
 A., and Frest, W. H.; Am. J. Hy june 71:122, Jan. 1933.

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When blood pressure must come down

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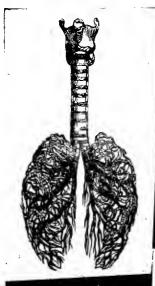
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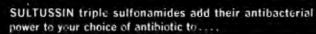
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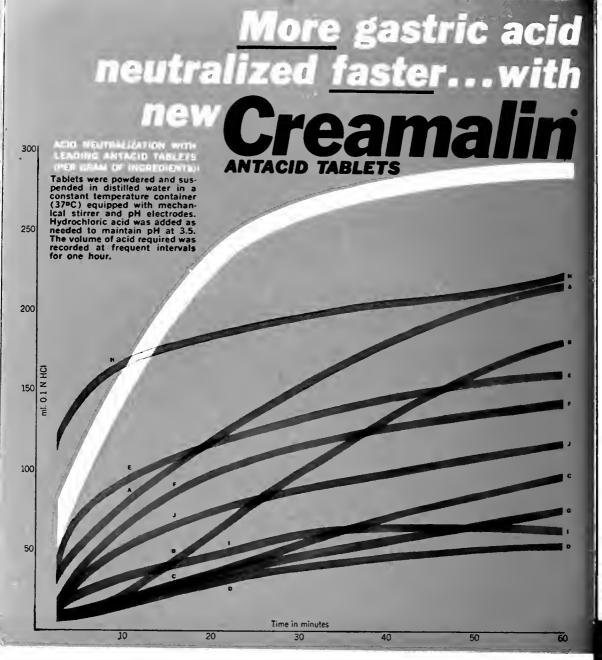
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1. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: J. Am. Pharm. A. (Scient. Ed.) 48:380, July, 1959. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: J. Am. Pharm. A. (Scient. Ed.) 48:384, July, 1959.



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Distribution of Deliveries Among North Carolina Physicians in 1958 With Some Implications for the Future

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Predictions indicate that the total number of livebirths in the United States will reach five million in 1960 and nearly six million by 1970. The over-all increase in population plus the increased demand of the American people for more and more medical service will result in a drastic increase in the amount of work which individual physicians will be expected to perform. There appears to be little hope of increasing, by any significant amount, the number of physicians to be licensed annually during the next decade. These estimates imply that the present caliber of medical service may be impaired as the result of unusually heavy demands upon the physicians. The Committee on Maternal Welfare of the North Carolina State Medical Society became interested in the problem as it applied to maternity care after it received a number of inquiries concerning the possible development of a nurse-midwifery system for the state. Accordingly the Committee set out to study the problem as it pertains specifically to the maternity situation in the State of North Carolina. Information regarding the distribution of deliveries according to the type and size of practice of the individual physicians was obtained and presented to the Committee. This information and a summary of the deliberations which followed are herein presented.

Method of Study

One of the purposes in studying the distribution of deliveries was to evaluate the effect of the sharp increase in the number of deliveries which has been predicted for the next decade. Accordingly estimates of the predicted number of livebirths in North Carolina for 1960 and 1970 were made (table 1).

These estimates indicate that North Carolina will have between 111,000 and 113,000 livebirths in 1960. It is estimated that by 1970 there will be between 119,000 and 125,000 livebirths. At best such predictions are subject to numerous errors. Our original calculations, based on birth rates from 1950 through 1957, were sharply reduced after the 1958-1959 birth rates became available.

Results of a study made by the Committee on Maternal Welfare, Medical Society of the State of North Carolina, James F. Donnelly, M.D., chairman.

Presented before a combined meeting of the Maternal and Child Health and Vital Statistics Sections of the American Public Health Association, Atlantic City, New Jersey, October 20, 1959.

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Table 1

Estimated	Number	of	Livebirths
North	Carolina,	19	60-1970

Year	Number
1960	111,000-113.000
1970	119,000-125,000

Physicians in the state filed 48,680 livebirth certificates for the period covering January to June, 1958. The names of each physician and the number of livebirth certificates which he signed were punched on standard IBM cards and an alphabetical tabulation by the physician's name was made. Frequent variations in the spelling of a physician's name as well as his method of signing the certificates were noted and corrected. The type of practice in which the physician was engaged was obtained by reference to the directory of the American Medical Association, the roster of the North Carolina State Medical Society, telephone directories from local communities. and by personal contact with the health officers of the respective counties.

We then tabulated the distribution of the signed livebirth certificates according to the size and type of practice. A reasonable estimate of the size of a physician's annual obstetric practice may be obtained by multiplying the total livebirth certificates obtained during the half-year period by two. Except in table 2, the livebirths were tabulated by occurrence rather than by residence since this more accurately portrayed the obstetric load carried by the physicians practicing within the state. In 1958 the number of resident livebirths was only 58 less than the number of total births by occurrence. The sample of 48,680 livebirths by occurrence represented 47.4 per cent of the total physician deliveries for the year 1958. A similar count of resident livebirths indi-

Table 2

Resident Livebirths by Attendant At Delivery in North Carolina 1958

Attendant	Number		
Physician Midwife and other	102,652 7,840		
Total	110,492		

cates that physicians attended 47.9 per cent of all resident livebirths for 1958. The sample thus appears to have excluded about 1 per cent of the livebirths which occurred. Since the closing date for the count was on July 5, it seems likely that a large portion of the 1 per cent could be accounted for by certificates which were not filed within the time limits.

Classification of Physicians

In 1958 there were slightly more than 3,000 licensed physicians in the State of North Carolina. Of these physicians, 1,464 signed livebirth certificates during the first half of 1958. The distribution of these physicians according to the type and size of practice is recorded in table 3.

Of the 1,464 physicians, 1,048 were identified as general practitioners. Another 32 were listed as specialists in other fields. some of which were actually general practitioners while others apparently were accidental attendants at the time of delivery. The list also included 121 surgeons, most of whom had signed less than 25 livebirth certificates. On the other hand, 18 had signed considerably more certificates, indicating that they actually conducted an obstetric practice along with their surgical specialty. Most of the surgeons, however, were presumably called in as consultants on cases which ultimately ended in surgical deliveries. The physicians in

Table 3

Distribution of Physicians by Type of Practice And Number of Livebirth Certificates Submitted North Carolina, January to June, 1958

Tune of Decesion	210211	Caronne	., , , , , , , , , , , , , , , , , , ,) 10 Jun					
Type of Practice	No. Livebirth Certificates								
	1-	26-	51-	76-	101-	126-	151-	176	Totals
	25	50	75	100	125	150	175	over	
House officer	24	4	7	2	_	2	1	2	42
General practitioner	617	278	98	28	16	6	3	2	1048
Other specialty	26	6	_	_	1	_	1	-	32
Surgeon	103	13	1	3	1	_		_	121
Obstetrician (non-Board)	6	10	11	6	7	3	8	5	56
Obstetrician (Board and .									
Board qualified)	17	36	20	24	13	7	1	5	123
Military	12	7	6	3	4			_	32
Other	8	2	_	_	_	_	-	_	10
Total	811	356	143	66	42	18	14	14	1,464

these three categories—general practitioners, specialists other than obstetricians, and surgeons—can, for all practical purposes, be considered together when estimating the percentage of obstetric patients cared for by the general practitioner. Thus 82 per cent of the physicians caring for maternity patients in North Carolina were either general practitioners or consultants to them.

The physicians designated as obstetricians were divided into two groups: those who were qualified by the American Board of Obstetrics and Gynecology and those who were not. The non-Board obstetricians consisted of two subgroups. Approximately half were general practitioners whose primary interest lay in the field of obstetrics and who over a period of years had restricted their practice to this specialty. The remainder had a wide variety of training beyond the level of an internship in obstetrics—some as much as two to two and a half years.

When these data are considered according to the individual type of practice, several items are noteworthy. Among the non-Board obstetricians, 13 out of 56 (23 per cent) had practices exceeding 300 deliveries per year. In contrast, only 6 out of 123 Board obstetricians (5 per cent) had practices of this magnitude. On the basis of the livebirth certificates signed, it appears that more than half the general practitioners performed less than 50 deliveries a year, and that 895 (85 per cent) had less than 100 deliveries a year. Considering the size of practice for all physicians regardless of type, 89 per cent performed less than 150 deliveries a year. Eight and onehalf per cent had from 150 to 300 deliveries a year, and only 2 per cent had more than this.

We were particularly interested in the physicians who had 300 or more deliveries a year, since this appears to be an extraordinary volume of work. There are no adequate standards available concerning the time required for adequate medical supervision of a maternity patient from the time she is registered until postpartum care is completed. The following estimate is based upon the private practice of obstetricians at the three medical schools in North Carolina, and is probably unnecessarily high. Prenatal care for the normal patient, including the initial visit and 10

to 11 subsequent visits, consumes about 12 hours. An additional 8 hours of the physician's time is required during labor, delivery, and the immediate puerperal period. Postpartum examination and hospital rounds in the later puerperal period consumes another 2 to 3 hours, so that the physician devotes approximately 24 hours to each obstetric patient. Therefore, the physician who performs more than 300 deliveries a year must devote considerably less than 24 hours time to each of his obstetric patients.

Among the 28 physicians who had more than 300 deliveries a year, there were only three instances in which this seemed to be necessary. In one situation the physician was an obstetric resident in a large metropolitan Negro hospital and was on call for all deliveries not attended by some other physician. In actual practice he performed only a small portion of these deliveries, although he signed all the birth certificates. In the two remaining instances, the physicians restricted their practice to obstetrics and were counted upon by the other physicians as well as the patients in the community to handle all cases in this field. Both physicians admit that they have been overburdened for many years. In July of 1958 both communities acquired additional physicians trained in obstetrics and gynecology, a step which should relieve the burden upon these two men. The remaining physicians who performed more than 300 deliveries a year in North Carolina did so by choice. In all the other communities concerned, the number of physicians is adequate to take care of the obstetric patients.

Distribution of Deliveries by Size and Type of Practice

In order to obtain some idea of the actual distribution of the deliveries, the total number of livebirth certificates for the first half of 1958 were tabulated according to the type and the size of the practice of the physician.

Eleven per cent of the certificates were signed by physicians who had submitted more than 150 livebirth certificates each for the first half of the year of 1958 and therefore presumably had practices exceeding 300 deliveries a year. Table 3 shows that only 2 per cent of the physicians accounted for this 11 per cent of the total de-

Table 4 Distribution of Livebirths by Type of Practice and Size of Practice North Carolina, January-June, 1958

	Number of Livehirths										
Type of Practice	0-50		5	51-100		101-150		150 and over		Total	
		Per		Per		Per		Per		Per	
	No.	Cent	No.	Cent	No.	Cent	No.	Cent	No.	Cent	
House officer	342	1.6	629	4.3	253	3.5	785	14.2	2,009	4.1	
General practitioner	17,145	80.2	8,191	58.0	2,583	36.1	976	17.7	29,195	60.0	
Other specialty	382	1.8	_	_	125	1.7	171	3.1	678	1.4	
Surgeon	915	4.3	294	2.0	116	1.6	_		1,325	2.7	
Obstetrician									, -		
Non-Board	444	2.1	1,198	8.2	1,177	16.5	2,378	43,2	5.197	10.7	
Board and Board Qualified	1,633	7.6	3,354	22.9	2,425	33.9	1,201	21.8	8,613	17.7	
Military	457	2.1	662	4.5	471	6.6	_	_	1,590	3.3	
Other	73	0.3	_	_	-	_			73	0.1	
Total	21,391	100.0	14,628	100.0	7,150	100.0	5,511	100.0	48,680	100.0	

liveries. Forty-four per cent of the deliveries occurred in practices of less than 100 deliveries a year, 30 per cent in practices of 100 to 200 deliveries a year, and the remaining 15 per cent in practices of 200 to 300 deliveries a year. Examination of these data according to the various types of practice revealed some interesting points. The general practitioners, including the specialists other than obstetricians, and surgeons, performed a total of 64 per cent of all of the deliveries (this group of physicians accounted for 82 per cent of all the physicians filing livebirth certificates). This figure is somewhat higher than the 52 per cent quoted by the Council on Medical Services of the American Medical Association. Obstetricians performed 28 per cent of the deliveries, with Board obstetricians accounting for 17 per cent. The remainder of the patients were delivered by house officers, military personnel, and others.

As expected, the general practitioners accounted for a larger number of deliveries than did any other category of practitioner. Most of these deliveries were in the smaller practices, however, 80 per cent being done by physicians who had less than 100 deliveries a year. Even so the general practitioners accounted for 18 per cent of the deliveries in the very large practice group of 300 or more deliveries a year. The non-Board obstetricians performed 2 per cent of the deliveries in the less than 100 deliveries per year category, 8.2 per cent of deliveries in the 100 to 200 per year category, 16.5 per cent in the 200 to 300 delivery per year category, and a huge 43 per cent of the deliveries in the 300 plus category, In contrast, Board obstetricians accounted for only 22 per cent of the deliveries in the 300 or more deliveries per year category. The

practice of the Board obstetricians was largely concentrated in the 100 to 300 deliveries per year category.

Analysis of Obstetric Load of Physicians
By Type of Practice

Number of patients

In order to obtain a crude idea of how many obstetric patients the physicians in North Carolina were actually handling and could handle, we computed the average and median number of deliveries per physician according to the type of practice (table 5).

The mean and medians were calculated on the basis of the livebirth certificates and multiplied by 2, as indicated previously, to give a rough estimate of the number of deliveries a year. The median number of deliveries appears to be a more logical figure to use when considering the actual work load of any group of physicians, because of a few individuals with very large practices. On this basis the non-Board obstetrician delivered a median of 179 patients a year—46 more than the median for the Board obstetrician. This difference is conceivably due to the fact that the non-

Table 5

Mean and Median Number of Deliveries
Per Physician Annually by Type of Praetice
North Carolina, January-June, 1958

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Horti Carolina	January-June, 1998					
Type of Practice	Number of Mean	Deliveries Median				
House officer	101	47				
General Practitioner	59	45				
Other specialty	44	20				
Surgeon	23	10				
Obstetrician						
Non-Board	196	179				
Board	152	133				
Board-qualified	137	108				
Military	104	89				
Other	. 16	3				

Board obstetrician does little, if any, gynecologic practice, and therefore devotes a larger percentage of his practice time to obstetric patients. The median number of deliveries a year done by the general practitioner was found to be 45. The median figure of 47 for the house officer is much more realistic than the 101 or mean average.

Number of hours

Speculating along these lines, a crude estimate of the number of hours devoted to obstetrics per week by type of practice can be, devoted by the general practitioner to each practice category by 24 hours and dividing by 52 weeks. Such speculation indicates that 21 hours a week are, or should be devoted by the general practitioner to obstetrics, 54 hours a week by the Board obstetrician, and 79 hours a week by the non-Board obstetrician. The latter figure appears totally out of line and suggests, along with the other data, that the patients of some of the non-Board obstetricians receive less than a desirable amount of maternity care. The simple addition of slightly more than one obstetric patient per month to the practice of each of the 1,464 physicians who filed livebirth certificates in the first half of 1958 would take care of the additional 22,000 possible livebirths predicted in 1970. This boils down to an addition of approximately four to five hours work each week for each physician, without allowing for an increase in the number of physicians who will be practicing obstetrics by the year 1970.

Methods of Meeting the Expected Increase in Number of Deliveries

It is obvious, however, that the almost certain increase in the number of deliveries would increase the demands on the physician's time. The demand will not be restricted to the field of obstetrics, but will be felt in other medical fields as well. The reaction of the Committee to this situation was not one of alarm, but rather one of watchful expectancy. There appeared to be four ways in which the problem could be resolved: (1) a substantial reduction in the birth rates by natural or artificial means, (2) an increase in the number of practicing physicians in North Carolina, (3) an increase in the amount of obstetrics

done by the physicians already available and (4) the introduction of some radically new method of providing obstetric care.

Reduction of birth rate

Artificial attempts to reduce the birth rate in order to solve this particular problem do not appear to be morally justified. In view of our expanding economy, the attempt to reduce the birth rate by this method seems totally impractical. It is conceivable, however, that the rising cost of hospital care may act as a deterrent to the increasing number of pregnancies. It is also conceivable that with the increasing demand on physicians' time the law of supply and demand will result in an increase in the physicians' obstetric fees, which may also tend to control birth rates. It is of interest to note that, in spite of the predictions for a much higher number of total births during the next decade, the birth rate per se in North Carolina has been falling steadily for the past several years. Numerous other factors enter into the natural control of birth rates, not the least of which is the marriage rate. According to the May, 1959, issue of the Metropolitan Life Insurance Company Bulletin, the marriage rate is continuing to drop in spite of our present economy and the fact that a large number of our population are now reaching the marriageable age. It seems essential to us, therefore, that before elaborate plans are made to handle a large number of births, such factors must be considered carefully and at frequent intervals.

Increase in number of physicians

It does not appear that the number of physicians to be graduated yearly from the medical schools now in existence or from those which will be established within the next 10 years will rise to a total of much over 8,000 a year. Physician-population ratios have often been used to support the argument that the number of physicians practicing in the United States is insufficient to provide the medical services considered essential according to the standards of this country. These ratios are often misleading and merely reflect a maldistribution of medical care which is more often the result of social and economic preferences on the part of the physician. As stated previously, there were only two

North Carolina physicians who were compelled to carry obstetric loads far in excess of what could reasonably be performed. In both situations the load has been reduced. In all the other communities where physicians had more than 300 deliveries per year, there were adequate numbers of other well trained men who could have shared the load. These large practices, therefore, were not the result of an inadequate supply of doctors, but rather of the physician's own popularity and his unwillingness to restrict his practice. This type of practice may lead to the so-called "perineal obstetrics" and to the failure of the physician conducting such a practice to keep up with modern advances in his field. On the other hand, the "perineal obstetrician" will be just that regardless of the size of his practice.

Although we were able to obtain the number of physicians licensed annually in North Carolina, it was impossible to obtain any valid information regarding those who are actively engaged in practice. For the years prior to 1958 we were also unable to obtain any information as to how many physicians were engaged in the practice of obstetrics and to what extent. It was, therefore, impossible to reach any conclusions concerning future physician-population ratios in North Carolina nor, of more importance, the physician-obstetrician-patient ratio. Such information is highly essential in order to evaluate the need for any drastic change in the method of handling maternity patients.

Increase in obstetric load of physicians

The third possibility considered was whether practicing physicians in North Carolina could carry larger obstetric loads than they were carrying in 1958. Although this question cannot be answered completely, it appears that they could. If it were just a matter of the additional maternity work required, this could be managed by adding an average of five hours a week per physician. Any increase in the number of physicians practicing obstetrics would tend to lower the demands upon this time. An extension of the group practice plan may be one way to permit a physician to handle his obstetric patients more efficiently. All the Board obstetricians with very large practices, those with more than

300 deliveries per year, were engaged in group practice. They all render a high grade of maternity care which most of their patients find totally satisfactory. Group practice makes it possible for the patient to have a physician in constant attendance, whether it be at the office, in the labor room, or in the operating room. The patient still has a free choice of physician or, in this case more correctly, physicians. A physician in the group is assigned to the labor and delivery room and remains there instead of racing back and forth between the hospital and his office. A group of five general practitioners recently set up a group practice in a rural mountain community in Western North Carolina, and are delighted with its efficiency.

Finally, many general practitioners in North Carolina are currently doing little or no obstetrics, primarily because of disinterest. Medical schools could do much to stimulate interest in this field. Many schools present obstetrics as an unpleasant, time-consuming chore, requiring a large volume of night work and capable of being performed by persons with limited training. Recent studies concerning the etiology of mental retardation, congenital malformations, and other central nervous system conditions emphasize the acute need for highly trained physicians who can provide maternity care of the highest standards. It would be much more logical to permit less trained individuals to suture simple lacerations than to supervise prenatal care, labor, and delivery. It appears to us that if obstetrics could be taught in such a challenging fashion, many more of our graduating physicians would remain interested in obstetrics when they enter practice.

New concepts of maternal care

The last alternative considered was the introduction of some entirely new concept of maternity care. One concept that has gained considerable recent support is that of the nurse-midwife, midwife assistant, or obstetric assistant. The nurse-midwife is utilized to a large extent in Great Britain, Europe and other parts of the world. It should not be confused with the granny-midwife system which is common in the southeastern part of the United States. Although schools for nurse-midwifery have existed in the United States for many

rars, a number of new ones have been tablished recently. Numerous objections the development of a nurse-midwife stem in the United States can be cited. or instance, the shortage of nurses is ren more acute than the shortage of phycians, and such a program might make e situation worse. Secondly, the current urse-midwife schools would have to be eatly expanded to provide enough nurseidwives to lower significantly the obsteic load which is being predicted for the ext decade. Although the nurse-midwives ow accepted for training are considered be of very high caliber, it is unlikely at this standard can be maintained if te schools are enlarged to any extent. hose favoring a nurse-midwife program ave pointed out that considerably less time required to train a nurse-midwife than train a physician. This is true as long s the trainee is a graduate nurse, but verlooks the fact that it requires three to our years to train a graduate nurse. For nese and other reasons the Committee exressed little interest in the development of nurse-midwife system in North Carolina.

An alternative to the nurse-midwife sysem as it is practiced in Great Britain and Lurope would be to provide additional raining in maternity care for graduate urses so that they could be of more assistnce to the physician with his patients, oth in the office and in the hospital. Disussing this point, Dr. N. J. Eastman pointed ut that the major objects of his nursehidwife school were two: (1) to train urse-midwives for the actual practice of bstetrics in foreign countries; and (2) to roduce nurses with advanced training in bstetrics who could assist physicians in his country in the administration of preatal care and management of labor, and vho occasionally could perform a delivery when the physician could not be present. t was our feeling that such a training program should extend beyond the nurse ind include other ancillary personnel such s the anesthetist. Persons so trained could elieve the physician of many routine duties and enable him to devote his time more fficiently to the medical care of his paients. The training program would also nclude the public health nurse, who could ielp in many ways such as in mothers' classes, care of patient at home, interpretation, and case finding. Plans for such a program are now being developed at one of our three medical schools, and it is hoped by the next year this program can be started.

Conclusions

We were all agreed that there will be a marked increase in the number of deliveries during the next decade. Whether or not this increase will be large enough to require the introduction of some new program for the care of maternity patients is not certain. It was felt, however, that continued observation of the physician's annual obstetric load is important. Accordingly, it was suggested to the North Carolina State Medical Society that pertinent data on physicians engaged in the practice of obstetrics be maintained on standard punch cards in order to detect any significant change in the distribution of deliveries or in the total obstetric load. The Society has accepted the suggestion, and since this time other committees of the Society have indicated an interest in acquiring the same sort of information about members of their own specialty.

Secondly, it was felt that the medical schools should be urged to provide leadership in interesting physicians in the field of obstetrics. Since at least half the physicians practicing in North Carolina do some obstetrics, it seems that this should be one of the subjects stressed in the medical schools. The growth of research in the field of cerebral palsy, mental retardation, and other central nervous system conditions in infants should do much to stimulate the interest of medical students.

Whereas there appeared little need for a fully developed nurse-midwife system such as Great Britain's, the Committee saw a distinct need for graduate nurses specially trained in the field of maternity care who could provide considerably more help for the busy physician in addition to better maternity care for the patients. Such specialized training could be extended to the public health nurse as well as to other professional persons.

The Medical Student, Specialization and General Practice

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For the past several decades, there has been an increasing tendency toward specialization in medicine and a corresponding decrease in the number of physicians devoting themselves to the general family practice of medicine. This trend has been deplored as tending to fragmentize medicine and to result in the patient's being treated as a series of separate organ systems or disease entities, rather than as an integrated psychobiologic unit. This argument may have some merit. But whether it has or not, the decrease in the number of physicians going into general practice has another undeniable effect. This is a corresponding decrease in the numbers of physicians manifesting an interest in practicing in smaller towns and rural areas. This factor is of particular concern to a largely rural or semi-rural state such as North Carolina, No doubt numerous factors influence the redistribution of physicians towards urban areas, but the trend towards specialization would seem to be among the more important. It was thought worth while, therefore, to examine some of the differences between physicians choosing specialties and those choosing general practice. A knowledge of these differences may give us some leads as to how we can influence the distribution of physicians more in favor of rural or small town practice.

A study being conducted at the University of North Carolina School of Public Health is inquiring into factors that influence physicians in their choice of particular specialties or types of practice.

Although our particular interest is in factors motivating physicians with respect to public health careers-either for or against -we are, of necessity, examining influences at work with respect to other specialties and to general practice. In the course of this study a survey has been made among students in a national sample of eight medical schools. The concept and plan of the study have been described elsewhere(1). Twenty-six hundred and sixty-seven students in these eight schools were queried concerning various factors motivating their current thinking concerning their ultimate fields of practice. In this paper we will examine some of the differences between those choosing specialties and those choosing general practice. The particular factors to be discussed are: size of home town, economic pressures, and, briefly, certain values or satisfactions which these students seek in the practice of medicine.

Distribution of Students With Regard to Ultimate Specialization

As an indication of the extent to which today's medical students think in terms of ultimate specialization, 53 per cent of the students in our sample showed interest in some specialty, 32 per cent intended to practice general medicine, and 15 per cent were still undecided. Judging from other data which will appear later, it seems likely that most of the undecided students will ultimately choose a specialty, so that something close to two-thirds of our sample can be described as being interested in or having decided upon specialized careers in medicine.

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From the School of Public Health, University of North Carolina, Chapel Hill.

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Sub-Committee on Recruitment of the Committee on Professional Education of the American Public Health Association under the chairmanship of Franklyn B. Amos, M.D. The Chairman of the Sub-Committee's Special Study Group which developed the plan for the research is John H. Venable, M.D. Substantial contributions have been made by B. G. Greenberg, Ph.D. as consultant.

Factors Influencing the Decision to Specialize

There seem to be two sets of factors which play a particularly important role n the decision to specialize. The first has o do with the kinds of economic pressures mpinging on the medical student; the second has to do with the kind of community ne comes from. There are, of course, other factors worth noting, but we have selected these two because they seem to have the greatest bearing on the problem at hand.

Economic pressures

Let us look at the economic pressures first. Whereas 40 per cent of the least affluent students intend to become general practitioners, this is true of only 22 per cent of the more prosperous ones. Fortysix per cent of the married students with children intend to enter general practice, as compared with only 26 per cent of the single, non-engaged students. Again, of those who expect to owe \$5,000 or more by the time they complete their medical training, 50 per cent choose general practice, as opposed to only 25 per cent of those who expect to have no debts. These data are summarized in table 1.

Financial pressures are also reflected in the career choices of various age groups. The older medical student feels that he has less time in which to establish a practice, and can therefore less easily afford the additional years of training for a specialty. Thus we find that only 11 per cent of the medical students under 20 years of age intend to become general practitioners, but the proportion increases steadily with age until it reaches 52 per cent of those 31 and

over.

Paradoxically, the decision to specialize appears to increase with year at school. Since seniors are likely to be older than freshmen, this would seem to contradict the earlier finding. Such is not the case, however. First of all, it should be noted that 22 per cent of the freshmen medical students were unsure of their intentions, as compared with only 4 per cent of the seniors. This decrease in the number of undecided accounts almost entirely for the increase in the proportion of specialists. The proportion choosing general practice remains at about the same level through all four years, suggesting that those who decide to go into general practice make their

Table 1

Career Intentions of Medical Students By Selected Characteristics

		Pres	hoice	
	General			
	Prac-		Unde	
Characteristics	tice	cialty	cided	No.*
Marital status				
Married				
With children	46%	47%	7%	(503)
Without children	32	56	12	(568)
Single	92	00		(000)
Engaged	33	54	13	(329)
Not engaged	26	55	19	(1,249)
Indebtedness	20	00	10	(1,240)
None	25	60	15	(1.440)
Under \$2,000	33	54	13	(518)
	40	44	16	(367)
\$2,000 to \$4,999	50	37	13	(337)
\$5,000 and over	อบ	31	1.0	(991)
Socioeconomic status	40	45	15	(646)
Average	40	45	13	(832)
Above average	39	48		
High	22	63	15	(1,198)
Age			00	(50)
Under 20	11	61	28	(53)
21-22	28	52	20	(688)
23-24	29	56	15	(999)
25-26	32	59	9	(505)
27-28	44	45	11	(235)
29-30	49	44	_7	(112)
31 and over	52	38	10	(78)
Year at school				
Freshman	32	46	22	(735)
Sophomore	33	49	18	(704)
Junior	34	54	12	(647)
Senior	28	68	4	(590)
Size of home town				
1,000,000 and over	19	63	18	(1,001)
250,000 to 1,000,000	25	58	17	(220)
50,000 to 250,000	29	56	15	(391)
2,500 to 50,000	38	50	12	(704)
Rural non-farm	58	35	7	(222)
Rural farm	60	33	7	(136)
Preferred size of place				
of practice				
1,000,000 and over	13	71	16	(785)
250,000 to 1,000,000	19	65	16	(452)
50,000 to 250,000	26	57	17	(543)
2,500 to 50,000	57	33	10	(747)
Rural non-farm	80	17	3	(103)

*Figures in this column represent the number of students in each category on which the percentages are based.

decisions earlier than those who ultimately become specialists.

Secondly, when we introduce both variables, we find that at every class level the older students are more inclined to enter general practice, and that at every age level freshmen are more likely to choose general practice than are seniors (table 2).

Size of home town

The second factor that appears to be closely related to career choice is the kind of community from which the medical student comes. The larger the city, the more likely he is to be aware of the extent of medical specialization, the opportunities involved, and possibly the greater prestige attached to it. The difference between big-

Table 2
Proportion Choosing General Practice
By Age and Year at School*
Year at School

		i cai a	r esculour	
Age	Freshman	Sophomore	Junior	Senior
Under 20	12% (48)	 (5)	— (0)	- (0)
	30 (421)			
23-24	34 (131)	34(323)	27(368)	18(175)
25-26	37 (62)	29 (59)	39(114)	28(270)
27-28	43 (44)	44 (64)	57 (60)	36 (67)
29 and over	62 (24)	52 (46)	58 (50)	40 (70)
*Figures in p	arentheses re	present the	number	· students
on which each	percentage i	is based.		

city and small-town boys is strikingly revealed in our data; where only 19 per cent of the students from cities of more than 1,000,000 chose general practice, 60 per cent of those from rural farm backgrounds did.

Nor are these differences entirely due to socioeconomic status. Our data show that the proportion of students choosing general practice increases as we move from urban to rural students at every socioeconomic level. It is also true, of course, that wealthier students from rural backgrounds are less likely to choose general practice than are their less prosperous counterparts: but the *most* prosperous students from rural backgrounds are more than twice as likely to be interested in general medicine as the least prosperous students from the largest cities, 45 per cent and 21 per cent respectively (table 3).

Table 3
Proportion Choosing General Practice
By Socio-economic Status and Size of Home Town
Socioeconomic Status

	Above								
Size of	A.	erage	Α.	verage		High			
Home Town		1		2		3			
1,000,000									
and over	210	(211)	25%	(256)	160	2 (534)			
250,000 to									
1,000,000	39	(56)	23	(56)	19	(108)			
50,000 to						12001			
250,000	41	(95 F	34	(125)	20	(171)			
2.500 to 50.000	48	(189)	43	(213)	31	(302)			
Rural non-farm	66	(70)	64	(91)	11				
Rural farm	64	(25)	63	(91)	45	(20)			
*Figures in parenth	eses re	present	the nu	mber of	stud				
which each percenta									

Size of community preferred for practice

These differences become even greater when we compare students in terms of the size of community in which they would like to practice. It is interesting to note that the medium-size cities appear to gain at the expense of the largest ones. Thirty-seven per cent of the medical students in our sample come from large cities, but only 29 per cent want to practice in such a setting. In

any event, of those who do want to practice in large cities, 13 per cent intend to enter general practice, in contrast to 80 per cent of those who prefer a rural setting.

To summarize our first set of findings, then, we see that medical students who are under various kinds of financial pressure are more likely to choose general practice; and that the smaller the community from which the student comes and the smaller the community in which he wishes to practice, the more likely he is to choose general practice.

Differences in Values Between Prospective Generalists and Specialists

Let us consider this question: Is it possible that the decision to practice general medicine in a smaller community is not merely a matter of economics, but reflects other differences which may be of great concern to the medical profession? To put it another way, is tomorrow's family doctor likely to be a second-rater who knew he could not make the grade in a big city and in a specialty, or has he made this choice because of financial pressures, different life and professional values, or both?

In order to attempt an answer, we divided the medical students in our sample into four groups: first, by distinguishing between those who chose general practice and those indicating interest in a specialty; second, by subdividing groups in terms of the size of community in which they preferred to practice. We thus wind up with 329 urban general practitioners, 1,145 urban specialists, 517 rural general practitioners, and 270 rural specialists. By comparing these four groups with respect to a number of variables, we are in a position to throw some light on our query.

First of all, let us take the various measures of economic pressure which we have already examined. As the data in table 4 indicate, urban specialists are under the least amount of pecuniary strain, and rural general practitioners report the greatest amount. Thus 63 per cent of the urban specialists expect to be entirely debt-free at the end of the senior year, while only 25 per cent of the rural general practitioners have such a happy prospect before them. Thirty-one per cent of the latter group are married and have children, as compared with 14 per cent of the urban specialists. Where 19 per cent of the urban

Table 4

Types of Practice	URI	elected 3AN Genera	R	rs URAI Gene	
	Spe- cialty (1,145)	Prac- tice	Spe- cialty (270)	Pra tic	e-
Father's Income	• , ,				
Under \$2,500	2%	4%	4%	7%	e e
\$2,500 to \$4,999	17	27	28	34	
\$5,000 to \$7,499	25	32	23	30	
\$7,500 to \$9,999	15	15	13	8	
\$10,000 to \$14,999 \$15,000 to \$24,999	20	11	15	11	
\$15,000 to \$24,999	11	6	11	5 3	
\$25,000 and over Fellowship or Other Aid	9 33	4 34	6 43	52	
Yes Could have continued	48	42	48	32	
without help Could not have contin-		44	40	02	
ued without help Indebtedness	37	44	38	50	
None	63	56	44	34	
Under \$2,000	19	19	23	20	
Under \$2,000 \$2,000 to \$4,999	10	13	17	20	
Over \$5,000	7	11	16	25	
Marital Status					
Married:					
with children	14	22	24	31	
no children	22	19	22	23	
Single:			4.4		
engaged	12	15	14	11	
not engaged	50 E:	44	38	35	
Financial Support from in Establishing Practice	[Famil	ıy			
Definitely	28	22	21	17	
Probably	29	29	24	25	
Probably not	25	30	30	29	
Definitely not	17	18	24	29	
Age					
Under 22	29	25	24	22	
23 or 24	39	35	41	33	
25 or 26	21	20	18	18	
27 or 28	7	11	9	14	
29 and over	5	9	7	12	
Size of Home Town	52	46	11	8	
Over 1,000,000	11	11	3	4	
250,000 to 1,000,000 50,000 to 250,000	16	20	11	9	
2,500 to 50,000	17	16	51	43	
Rural non-farm	3	6	14	21	
Rural farm	1	1	11	15	
Expected Salary at Heig	ght of	Career			
Under \$15,000	4	6	10	15	
\$15,000 to \$19,999	14	25	23	28	
\$20,000 to \$29,999	41	$\frac{42}{16}$	43	41	
\$30,000 to \$39,999	25	9	$\frac{14}{9}$	$\frac{12}{2}$	
\$40,000 and over Job Values*	15	ð	ð	-	
Warm personal					
relationships	54	59	57	65	
Act as counselor	39	43	40	47	
Help people	69	69	72	76	
Prestige among medic	al				
colleagues	39	32	32	30	
High level of skills	52	34	42	32	
Exacting problems	30	20	30	18	
Contribute to	0.0	00	9.0	0.0	
knowledge	. 38	22	29	20	
Independence and sma		59	60	70	
salary Close doctor-nationt	55	υð	00	10	
Close doctor-patient relationship and					
supervision	54	67	56	70	
·Percentages represent prop	ortion	designat	ing va	rious	job
values as personally indisper	asable o	r extren	nely im	porta	ıt.

specialists report family incomes of less than \$5,000, 41 per cent of the rural general practitioners do. Twenty-eight per cent of the urban specialists definitely count on help from their families in establishing their practices; only 17 per cent of the rural general practitioners do the same. Finally, more of the rural general practitioners are receiving fellowships or other aid than any of the other groups, and of those who are receiving such aid, a larger proportion of the rural general practitioners report that they could not complete their studies without such aid.

In any event, our findings in this connection are unchanged: students who choose general practice, and particularly those who choose to settle in a small community, are under greater financial pressures than are those who want to specialize, especially in large cities.

But none of the foregoing differences are as great as the one we find with respect to the size of home town. Here we see that urban specialists are somewhat more likely than urban general practitioners to come from cities of more than one million population, and that rural general practitioners are somewhat more likely than rural specialists to come from rural backgrounds; the big differences, however, are not between specialists and general practitioner, but between those who want to work in urban centers and those who want to practice in rural areas. Whether a medical student intends to practice general medicine or a specialty, the size of community he selects appears to depend largely on the size of community he comes from. This finding suggests that, unless there are systematic differences with respect to intelligence and ability between urban and rural medical students, and there is no evidence to support such an assumption, the decision to practice in a small town is not a function of significantly lower ability or medical aptitude. There is greater reason to suspect that medical students who choose to become country doctors do so partly because they are not as well off as other medical students, but even more so because they come from small towns, and entertain personal and occupational values which are better suited to small-town life.

Achievement vs. personal relations

We do not propose at this point to launch into a full-scale account of the differences in life attitudes and values between bigcity and small-town people. It is enough to say that, while modern highways and the mass media of communication have probably done much to reduce these differences, urban dwellers are on the whole more concerned with achievement—as measured by such things as income and professional standing. Residents of rural areas, while they do not despise achievement, are more prone to emphasize the importance of interpersonal relations as ends in themselves.

Let us take, for example, the matter of income expectations. Students were asked to specify the incomes they hoped to be receiving at the height of their careers. Of the urban specialists, 40 per cent expected to earn more than \$30,000, and 15 per cent to earn more than \$40,000. Rural general practitioners had much lower expectations. Only 14 per cent expected to earn \$30,000 or more and only 2 per cent hoped to make more than \$40,000. At the other end, while only 4 per cent of the urban specialists expected to be making less than \$15,000, 15 per cent of the rural general practitioners were in this category.

Not only did the prospective rural general practitioners expect to have lower incomes; their professional values were also likely to differ from those of other medical students, particularly those of urban specialists. Thus, in specifying various aspects of the ideal job which they regarded as indispensable or extremely important, urban specialists were least likely. and rural general practitioners most likely, to mention developing warm personal relationships with patients, being looked up to as a counselor by patients, and having the chance to help people. The rural general practitioner thus sees his role as conforming more closely to the image of the "horse-and-buggy" doctor. In the same way, rural general practitioners were less likely than any other group, particularly urban specialists, to regard as important such values as professional prestige, opportunities requiring a high level of ability and skill, problems demanding exacting analysis, and opportunities to contribute to knowledge. To put it another way, rural

general practitioners are somewhat more likely to subscribe to what has been called the art of medicine, and urban specialists to the science of medicine. It is interesting to note that precisely the same differences have been found between nursing students from rural and urban backgrounds⁽²⁾.

Independence vs. income

In an attempt to confirm this interpretation, let us look briefly at another portion of the data. Students were asked to choose between various kinds of work situations in which getting one thing meant giving up something else. For example, they were asked to choose between a job which offered independence and a salary of \$8,000 and one which involved working under supervision but with a salary of \$20,000. Fifty-five per cent of the urban specialists, and 70 per cent of the rural general practitioners preferred to be independent but relatively low-paid. Another pair of alternatives involved having a close physician-patient relationship and working under supervision as against having little or no relationship with patients but being free of supervision. In this case, 54 per cent of the urban specialists chose close relationships, as against 70 per cent of the rural general practitioners. In other words, rural general practitioners were more willing to sacrifice money for freedom from supervision, but they were also more willing to sacrifice independence for the chance of maintaining close relationships with patients.

It should be noted, however, that while differences between urban specialists and rural general practitioners with respect to values are consistent with our expectations, this is not the case when we compare urban general practitioners and rural specialists. Here we find some interesting reversals: urban general practitioners are slightly more concerned with interpersonal relationships and less concerned with the professional aspects of medicine than are rural specialists. In other words, the attitudes of the urban specialist toward his career resemble more those of the rural specialist than they do those of the urban general practitioner; and conversely, the rural and urban general practitioners are more alike than are rural general practitioners and rural specialists. This means that, while the kind of community in which one wishes to

March, 1960

practice is related to one's professional atitudes, the type of intended practice cuts cross these considerations and is independently related to the attitudes in quesion.

Summary and Conclusions

A survey of 2,667 students in eight nedical schools indicates a number of diferences between medical students choosng specialties and those choosing general ractice. Those choosing general practice ire more likely to have less financial reources, are more likely to come from small owns or rural areas and to want to return o similar areas; expect smaller incomes; are likely to be older when they enter medcal school; are more interested in close personal relationships with patients and ess interested in high status; are more inerested in helping people, but less in-erested in utilizing highly developed skills or making a contribution to knowledge. Let is hasten to add that this does not imply that either group is lacking in any of these 'favorable" attributes or are overburdened with any of the "unfavorable" ones. We have simply compared the degree to which these qualities occur in the two groups.

Another caveat which should be added is that we are here dealing with data concerning medical students' current plans for the future. Things may happen to them during internship, residency, or the ever present military service which may change their

views.

Nevertheless there are some implications here for increasing the number of physicians going into general practice and concomitantly the supply of physicians to rural areas. Among these is the very great value to be derived from scholarships and loan funds such as the one administered by the North Carolina Medical Care Commission. Such financial aid will make it possible for many students to attend medical schools who otherwise might not be able to do so, and it is from this very category that are derived the largest number of physicians interested in rural practice.

It goes without saying that we should encourage to enter medicine only young people of the highest character and who have a real interest in people. Special efforts directed toward young people of this type who live in small towns or rural areas, however, should result in more physicians returning to those areas to practice.

It is expected that further analysis of our data will reveal more information pertaining to the motivations of physicians in selecting particular types of practice or particular locations. A knowledge of such factors can go far toward guiding medical schools, medical societies, and communities in taking measures designed to bring about the optimum distribution of physicians for the best medical care for the entire population.

References

- (a) Back, K. W., Coker, R. E., Jr., Donnelly, T. G., and Phillips, B. S.: Public Health As a Career in Medicine: Secondary Choice Within a Profession. Am. Sociological Rev. 23:533-541, 1958. (b) Coker, R. E., and others: Public Health as Viewed by the Medical Student, Am. J. Pub. Health 49:601-609 (May) 1959.
- Goldsen, R. K., Suchman, E. A., and Miller, N.: The Choice of Nursing As a Career, Cornell University, 1958 (unpublished).

Before prescribing a preparation each physician should make use of the simple guides and ascertain if his knowledge and the merits of the proposed agent are such as to warrant its use. Furthermore, in these days of ever-increasing costs no drug preparation should be prescribed until the physician has some idea of the cost. Frequently, much less expensive and as good or nearly as good alternate agents are available if the physician informs himself about cost and devotes sufficient time to drugs and their uses so that he can wisely select alternate preparations.—Friend, D. G.: Polypharmacy—Multiple-Ingredient and Shotgun Prescriptions, New England J. Med. 260:1017 (May 14) 1959.

Breast Feeding: Going or Coming? And Why?

Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P.*

BLACK MOUNTAIN AND ASHEVILLE

Down through the ages, the only food on which an infant could be safely nourished has been human milk. In the old days, if a mother were too high and mighty to be willing to manufacture this product for her baby and could afford to procure it, or if she were so poor as not to be able to do so, there was one recourse: She might secure another source of human milk in the person of a substitute mother called by the highly expressive name, "wet nurse." If for any reason this person ceased to be "wet", some one else had to be provided. If you wanted to give the baby his best chance for life, it was someone else, not something else that had to be provided. It wasn't a substitute food, it was a substitute source of food, that gave the baby his best, and often his only, chance for survival.

To be sure, from time to time someone would try to dress up some substitute food to offer the unfortunate youngster deprived of his birthright. Such "pap" might be "panada" (bread crumbs boiled in milk or broth) or "caudle" (wine or ale with bread, sugar and spices). Or they might try the milk of asses, goats, mares, or cows⁽¹⁾.

But the shockingly high toll of infant deaths, and the terrifying percentages of infant mortality when records began to be kept, gave proof of the practical indispensability of human milk for the human young. The artificially fed baby's chances of staying alive were about one to the breast fed baby's ten.

It was around the turn of the century that serious attention began to be given by doctors to devising something in the way of acceptable food for the baby whose mother could not provide for him. Analyzing human milk and trying to concoct a substitute for it was a fascinating pursuit. But attempts to "modify" the milk of the

horse, the goat and the cow all failed to make the grade, no matter how scientists added lactic acid, various kinds of sugar, or diluted it and boiled it. The mortality still remained high.

For a great many years, farmers, veterinarians and the agricultural schools have been deeeply concerned with studying lactation in the cow, and with improving both the quality and the quantity of the bovine yield, as well as safeguarding it from the standpoint of cleanliness and sanitation.

Why should doctors, and medical scientists generally, have overlooked the equally fascinating field of research into lactation in the human, instead of concentrating their efforts on the thus far hopeless problem of supplying the hundred-odd dietary elements that human milk has been believed to contain? This question is hard to answer. It may have been because the physical is so much easier to deal with than the psychological and emotional. And there is so much of the latter involved in human lactation that, until this fact was realized, the problem could not be adequately dealt with.

Which Mothers Can Breast Feed Their Babies?

There has never been any serious doubt that breast feeding is the best feeding. The only question has been as to whether it could be obtained. By the beginning of this century, it had come to be regarded more or less as an act of God—a good trick if you could do it, but you probably couldn't. Everybody talked about it, but like Mark Twain's crack about the weather, nobody did anything about it, until in the second decade a young pediatrician, Julius P. Sedgwick, came back to Minneapolis after some years' study in Germany.

At that time, doctors generally advised their patients to breast feed their babies if they could, since from 4 to 6 bottle-fed babies died to one who was breast fed. Questioning 500 doctors, Sedgwick found

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that four-fifths of their own babies were nursed three months or longer, while twothirds of them nursed for nine months or more.

He worked out a plan by which the mother of every baby born in Minneapolis during a test period was visited by a nurse who explained the technique of breast feeding. As a result more than nine-tenths of these Minneapolis babies were kept on breast milk for one month, and more than two-thirds were still nursing at the end of a year⁽²⁾.

In 1925 and 1926 almost identical figures were obtained in a demonstration conducted in Nassau County, Long Island, by the New York State Department of Health in cooperation with the Brooklyn Pediatric Society and the local doctors. Small "daughter demonstrations" in other parts of the state gave even better results. It has thus been proved conclusively that almost any mother whose doctor wants her to, can nurse her baby as long as she wishes⁽³⁾.

"During the siege of Paris in the Franco-German War, while the general mortality doubled, the infant mortality fell 40%, because women did not go to work but stayed home and nursed their babies." (L. Emmett Holt) (4). And "before the occupation of Paris in World War II, breast feeding was only 38%. But during the German occupation, with milk hard to get, 90% of mothers discovered they could nurse their babies." (Niles Newton, Ph.D.) (5)

Trends and Counter Trends in Breast Feeding

In spite of this evidence, breast feeding in the United States seems to be declining. Bain in 1948 reported that 1/3 of the babies were weaned at the time of discharge and 2/3 were on breast or mixed feedings. The percentage of breast-fed babies was smaller in hospitals near metroplitan centers, and smaller in the Northeast than in the Southwest or Southeast⁽⁶⁾. Ten years later, Dr. Herman F. Meyer of Chicago, after an extensive study of nearly 3,000 hospitals, with replies from nearly two-thirds of them, comments:

"There are fewer infants breast-fed at the time of discharge than there were ten years ago." (7) He adds in a personal communication to the writer:

"A strange paradox is taking place. While the incidence of breast feeding is declining generally,

in the higher income and itellectual levels of the country it seems to be increasing! Various studies all show an increase of interest and carrying out of this ancient art by these strata of society.... In both lay and medical literature, the modern mothers are reminded that this ancient practice is still an important requirement of successful motherhood."

In recent years a somewhat surprising, and to this writer rather significant, trend has been taking place. This is a movement on the part of mothers, present and to be, that provides for expectant parents a sizeable portion of the services rendered until recently by their family doctors, pediatricians, and obstetricians.

As this writer sees it, these young women and their husbands have been experiencing an inarticulate but none-the-less real dissatisfaction with the services many of their medical attendants have been rendering in certain areas, and have been banding together to do something about it. These areas of dissatisfaction and proposed remedies are:

- 1. The lack of physical and emotional preparation for childbirth, the unnecessary use of anesthesia, and the exclusion of prospective fathers from the delivery room. (Natural Childbirth)
- 2. The unnecessary prescription of artificial feeding, and failure to encourage breast feeding. (Breast Feeding)
- 3. Rigid rules as to quantities, intervals, and duration of feeding. (Demand Feeding)
- 4. The separation of baby from mother in a nursery for newborns, and failure to utilize time in hospital for training mother and father. (Rooming In)
- 1. The first, an obstetric problem, is out of my province, though it has been interesting, and at times amusing, to watch the struggles of some of my obstetric brethren in this field.
- 2. I have been personally interested in the second problem, more intensely since I initiated and directed the Nassau County, New York, Breast Feeding Demonstration.
- 3. The third proposal, Demand Feeding, I have embraced whole-heartedly, in spite of the three and four-hour feedings I used to insist upon.
- 4. And I have been strongly impressed with Rooming In, as it has been practiced optionally in our hospitals in Asheville, and

wholly in the Duke University Hospital in Durham.

All of these areas are well covered by *Child-Family Digest*, a non-profit magazine devoted to emphasizing these modern trends in the development of a better family life.*

I doubt whether the medical profession is sufficiently aware of this movement springing up in various sections of our country, always with medical backing and encouragement, to bring about reforms in all these fields. These organizations are known as "classes for expectant parents." An outstanding example is the one known as La Leche League (la leche is Spanish for milk) of Franklin Park, a suburb of Chicago, founded a few years agot. Its purpose is to explain, discuss, and advise on breast feeding. A series of five meetings points out the advantages of breast feeding to mother and baby; explains the necessary know-how of nursing; discusses weaning; suggests good procedures during pregnancy and at the time of delivery; and promotes good nutrition for the nursing mother.

Inquiries have come in from 30 states. A bi-monthly newsletter has been started, and now what began as a correspondence course on breast feeding has developed into a 28-page brochure entitled "The Womanly Art of Breast Feeding." (8)

La Leche takes this view of the history of breast feeding and formula making by the medical profession;

"The medical profession tackled the job of finding an acceptable milk for the baby who could not get breast milk. And with the help of refrigeration, sterilization and the rubber company, the modern formula was delivered for the exceptional case. Then somehow the exceptional became the rule, and bottle feeding often led to a whole new manner of 'mothering.' In the midst of scales and charts, mothers began to lose confidence and miss the natural enjoyment of a new baby.

"Now psychiatrists are pointing out that the natural inclinations of a mother to hold and nurse her baby should not be ignored. The original plan for care and feeding bears re-examination. Many forward-looking doctors are taking a backward glance, and are recommending breast feeding. The doctor, who is well grounded in prescribing formula, has had little opportunity to learn about the woman's rôle in breast feeding."

This quotation from the Introduction to "The Womanly Art of Breast Feeding" is indicative of the sound psychology and common sense that characterizes every page of this little publication, devoted exclusively to the advantages, problems and difficulties connected with breast feeding Any doctor who wishes to improve breast feeding techniques and increase his percentage of breast fed babies and contented mothers will do well to add this brochure to his book shelf of practical working manuals.

Another example of non-medical preparation for parenthood, with a strong 'emphasis on breast feeding, is the Catholic Family Life Program, which puts out a veritable encyclopedia of helps for better family living entitled *Preparation for Christian Parenthood: A Pre-Natal Course of Instruction*, by Rose Gioiosa, R.N. B.S. (9) Courses are given in various parts of the country, using this as a text. It emphasizes the advantages of breast feeding, and offers suggestions for maintaining it.

It should be distinctly understood that this lay effort is not in any sense a revolt against medical care at the hands of medical men. On the contrary, wherever the movement has started it has relied on the guidance and support of outstanding medical men in the community. In fact, many of the sessions are taught by pediatricians, obstetricians, general practitioners, psychiatrists, and registered nurses.

For the benefit of the obstetricians, pediatricians, general practitioners, and others who may be interested in the current revival of interest in breast feeding as the best and most readily available source of infant food, an article read before the Section on Pediatrics of the American Medical Association in 1949 surveys "the voluminous literature on breast feeding... and the lactating breast." (Reprints of this article may be obtained on request from Dr. F. H. Richardson, Children's Clinic, Black Mountain, North Carolina.)

A well known writer says:

"This declining incidence of breast feeding among American women is not the result of lack of willingness. Most primiparas express a desire to breast feed, only to be defeated in the first few days or weeks under the system of neonatal care which prevails in a majority of hospitals today.

^{*}Edited and published by Gayle (Jr.) and Charlotte Aiken. 5320 Daneel Street, New Orleans, Louisiana.

⁻La Leche League, 3020 La Porte, Melrose Park, Illinois.

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Prominent among these factors is the lack of a hospital personnel really interested in promoting breast feeding. Here the medical profession must share the blame with the nursing profession. Discussion with the obstetrician about what preparations for nursing the pregnant mother should undertake, apparently occurs only rarely. Few nursing staffs have one or more nurses especially skilled in the art of hreast feeding who are available for advice and assistance in the immediate postpartum period when such services are particularly important. It seems clear that the present downward trend in breast feeding could be reversed if there was any great interest on the part of the medical and nursing profession to do so."(11)

Conclusion

What then does this movement mean? In my opinion, it indicates that a renaissance is taking place in the minds of a great many of our most thoughtful young married people. It indicates a revival of the age-old conviction that nature is more reliable than science, that mother-love is more effective than aseptic precautions. It suggests that doctors are going to have to give more thought to the convenience and desires of their patients than to their own inclinations.

An inescapable corollary to this proposition is the conclusion that medical scientists are going to have to wake up to something discovered long ago by their brethren of the agricultural and veterinary colleges. That is that milk production is more deserving of study than is milk modification. And our medical schools are going to have to teach their students how to improve and increase the yield of human milk producers. This is indeed a worthwhile study.

References

- Best For Baby, M.D. Medical-Newsmagazine 2:113 (Nov.) 1958.
- Sedgwick, J. P.: A Preliminary Report of the Study of Breast Feeding in Minneapolis, Am. J. Dis. Child 21:455 (May) 1921.
- Richardson, F. H.: (a) Universalizing Breast Feeding in a Community, J.A.M.A. 85:668-671 (August 29) 1925.
 (b) Progress of Breast Feeding in New York State, J.A.M.A. 89:1487-1489 (Oct.) 1927.
- Holt, L. E.: in Richardson, F. H.: The Nursing Mother: A Guide to Successful Breast Feeding, Tupper & Love, 1953, p. 27.
- 5. Newton, N.: in Richardson (4).
- Bain, K.: Incidence of Breast Feeding in Hospitals in the U. S., Pediatrics 2:313 (Sept.) 1948.
- Meyer, H. F.: (a) Infant Feeding Practices in Hospital Maternity Nurseries, Pediatrics 21:288-297- (Feb.) 1958.
 (b) Breast Feeding in the U. S.; Extent and Possible Trend, Pediatrics 22:116-121 (July) 1958.
- The Womanly Art of Breast Feeding, La Lecbe League of Franklin Park, Inc., 3332 Rose Street, Franklin Park, Illinois.
- Giosiosa, R.: Preparation for Christian Parenthood: A Prenatal Course of Instruction, Washington, D. C., Family Life Bureau, National Catholic Welfare Council.
- Richardson, F. H.: Breast Feeding Comes of Age, J.A.M.A. 142:863-867 (March 25) 1950.
- Hill, L. F.: Infant Feeding at the Midcentury, Journal-Lancet 76:69-76 (March) 1956.

Women, more and more, may be entering the man's world, but they remain the weaker sex—at least, in terms of their work record in industry. Evidence for this fact is revealed in the current issue of *Patterns of Disease*, prepared by Parke, Davis & Company for the medical profession. More women in industry are posing 'new health problems', particularly in terms of absenteeism, the publication reveals.

It points out that the number of women employed has increased by 50% during the past 10 years, to the point where they now comprise one-third of our working force. Of the 22,000,000 women workers, about 9,000,000 are married while 1,000,000 or more are heads of families with no employed relatives. The median age of women workers increased by more than 6 years between 1946 and 1956, in contrast to an increase of less than 2 years in the median age of working men.

The problem of absenteeism among women workers has been under investigation, *Patterns* reports. In one company women constituted only slightly more than 25% of the working force, yet were responsible for 49% of disability cases, 63% of weeks lost from work, and 95% of excess lost time cases. "Most excessive absenteeism was among married women 50 to 20 years old and season of greatest absenteeism was summer—when children were on vacation from school!"

Abnormal Water Retention Associated With Carcinoma of the Lung:

Report of a Case With Hyponatremia

RICHARD M. PORTWOOD, M.D. JOHN V. VERNER, M.D. and E. E. MENEFEE, M.D.

In a recent paper, Schwartz and others(1) described 2 patients with carcinoma of the lung whose course was characterized, in part. by persistent and severe hyponatremia and excessive renal sodium loss(1). Careful balance studies revealed that primary water retention preceded salt wasting, and that the 2 patients responded in a strikingly similar manner to previously described normal subjects during prolonged Pitressin administration, with free access to water⁽²⁾. Because of this similarity, and in view of the finding in his cases of persistently hypertonic urines, Schwartz has suggested that excessive and "inappropriate" secretion of antidiuretic hormone (ADH) or ADH-like substances was the causal factor in the development of hyponatremia in his patients.

hyponatremia Recently, severe marked urine hypertonicity were noted in conjunction with probable carcinoma of the lung in a patient at Duke Hospital, Although the patient's clinical condition precluded the performance of detailed balance studies, it was felt that the observed water and electrolyte disturbance possibly resulted from an excess of ADH activity, and that the case was of sufficient interest to warrant the present report.

Case Report

A 47 year old male shipping clerk was well until five months prior to his admission to Duke Hospital on February 1, 1959. when he experienced the onset of pleuritic chest pain on the right and a dry, hacking cough. There were no systemic symptoms provement occurred with antibiotic admin-

at this time, although a routine chest roentgenogram showed an infiltrate in the right lung field extending from the apex to the fourth rib anteriorly. Transient im-

istration, but the symptoms of chest pain and cough returned in two weeks and progressed until the time of his Duke admission. Although there was no fever or weight loss, the patient did note increasing fatigue and malaise, and the cough became productive of large amounts of blood-tinged sputum. A repeat roentgenogram at an outside facility showed no improvement in the chest lesion, so he was referred to Duke Hospital for evaluation.

The past history was significant in that he had smoked one and one-half to two packs of cigarettes daily since 20 years of age. The physical examination on admission disclosed a blood pressure of 130 systolic, 70 diastolic, pulse rate of 108 per minute, and other vital signs within normal limits. He appeared chronically ill, but was in no acute distress. There was distention of neck and arm veins on the right, suggesting a partial large venous obstruction on that side. The right side of the chest moved poorly with inspiration, and breath sounds were harsh over this side of chest anteriorly. The heart was not enlarged. The liver edge was felt 1 cm. below the right costal margin and was non-tender. There was no edema, and the extremities showed no clubbing or cyanosis.

The admission laboratory data revealed hemoglobin concentration of 12.8 Gm. per 100 cc. and a white blood cell count of 8.300 with normal differential count; urinalysis was not remarkable. A chest roentgenogram showed a mass at the right hilum and increased density in the right middle and upper lobes, with some honey-combing in these areas. The roentgen picture seemed most compatible with a carcinoma at the hilum of the lung with obstruction to the right main stem bronchus and secondary infection. Bronchoscopic examination disclosed edema and fixation of the right main stem bronchus. Although the impression of

From the Department of Medicine and Division of Endocrinology, Duke University, Durham, North Carolina,

March, 1960

the bronchoscopist was that this finding represented carcinoma of the lung, biopsy of the lesion yielded only inflammatory tissue. A right supraclavicular node biopsy showed only non-specific inflammation on microscopic examination.

The patient's initial course in the hospital was uneventful. He was alert and well oriented, and in no distress. Because of the roentgen changes and the development of a low grade fever, he was treated with antibiotics in an attempt to relieve the secondary infection. He showed improvement initially, with a return to normal temperature and a decrease in his cough, until about the nineteenth day, when his mental status began to change. He became more restless and talkative, but retained normal orientation. On the seventeenth hospital day, serum electrolytes were determined, and he was found to have severe hyponatremia and hypochloremia (table 1). On examination at this time he had bounding pulses, full veins, vigorous heart action, a rise in blood pressure to 140 systolic, 90 diastolic, and a moist tongue. The 24 hour urinary 17-hydroxy corticoids were determined and found to be normal (6.1 mg. per 24 hours) as were the 17 ketosteroids (13.8 mg. per 24 hours). By the twentieth day he had become maniacal, and was transferred to a psychiatric ward.

At this time efforts were made to elucidate the mechanisms responsible for the profound hyponatremia. Because of the patient's mental state and uncontrollable behavior, it was impossible to determine balance of water and electrolytes with any degree of reliability. Several interesting points, however, emerge from inspection of table 1. Despite the significant reduction of the serum (Na+) and total serum osmolarity (as determined by freezing point depression with the Fiske apparatus)*, there was persistent and striking urine hypertonicity, which in the absence of evidence suggesting circulatory collapse or, more specifically, renal vascular insufficiency(3) likely reflected a persistent release of ADH, occurring despite the lowered serum tonicity. The administration of a massive oral water load was not followed by diuresis or a lowering of the urine osmolarity. On the contrary, the water produced a further depression in serum osmolarity (to 230 mOs per liter) and, possibly, further deterioration in mental function. Although there was no specific evidence

Table 1

Clinical Course of Patient Terminally Ill With Carcinoma of the Lung

Day	Fluid B Intake		Blood Urea Nitroge mg. per		К+	Serum Cl	$\mathrm{CO_2}$	Osm.	Urine Osm.	
	ml./24	hrs.	100 сс.		mЕ	q./L.	I	nOs./L.	mOs./L.	Remarks
1		_	15	_		_		_	_	Clear sensorium
16	_	_	_	112	4.7	77.9	20.1	_	-	Disoriented
19	_	_		116	4.3	82.7	24.3	_	_	
20	790		_	_	_			_		Urinary Steroids: 17-OH Corticoids 6.1 mg./24 hours 17-Keto-steroids 13.8 mg./24 hours
21	515	_	13	128	4.2		22.7	262	745	Maniacal
22	515	380	16	129	4.6	93.7	25.4	_		
23	1840	450		130	4.7	90.9	-	260	718	Intake includes 1500 ml. of water given orally
24	130	840		_		_	_	230	766	Hydrocortisone, 200 mg. administered parenterally during this period
25	745	575			_	_	_		718	
39	_	_	_	-	_	_			-	Death from massive pulmonary hemorrhage

suggesting adrenal insufficiency, hydrocortisone was given in large doses parenterally (on the day following the water loading test) to explore the possibility that an excess of glucocorticoid might oppose the action of ADH at the renal tubular level(4). No significant response was noted.

With restriction of water, the patient's mental status gradually improved and the hyponatremia was partly corrected. continued to cough up large amounts of blood (12 cup daily), and the cough became much more incapacitating, and was associated with dyspnea on slightest exertion. It was decided that the patient had carcinoma of the lung, as the right hilar mass had persisted and even possibly progressed during his hospital stay. At the patient's and family's request he was discharged on March 10, 1959, to the care of his local physician. Three days after discharge, while in his home, he had a massive and fatal hemoptysis. Permission for autopsy was not granted.

Comment

This patient, suffering presumably from carcinoma of the lung, manifested marked serum hypoosmolarity, hyponatremia, and persistently hypertonic urine, even when challenged with a substantial water load.

Of the usually encountered causes for hyponatremia, several can be excluded easily from consideration in this patient. There was nothing in the history to suggest chronic renal disease or urinary tract obstruction; the urinalysis was not remarkable; azotemia was not present. Adrenal insufficiency seemed unlikely in view of the normal urine steroid levels, as well as the absence of clinical evidence of circulatory impairment. The steroid excretion values would also argue against water retention stemming from hypopituitarism and secondary adrenal hypofunction. Excessive gastrointestinal loss of salt would be quite unusual in a patient presenting with neither vomiting nor diarrhea.

More difficult to dismiss is the possibility that the disorder in electrolyte and water metabolism resulted from chronic pulmonary disease or cerebral disease. "Pulmonary salt wasting" with resultant hyponatremia has been described; it classically occurs against a background of severe, long-standing pulmonary tuberculo-

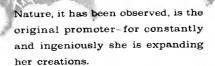
sis(5). It is conceivable, at least, that pulmonary neoplastic disease could also produce a similar salt-wasting syndrome. It is apparent that the distinction between the patient producing excessive amounts of ADH and the pulmonary salt-waster is difficult to make. Urine hyperosmolarity in the face of hyponatremia does not per se imply primary oversecretion of ADH. Leaf 6 has shown that primary salt depletion in otherwise normal animals leads to impaired water excretion and to persistent urine hypertonicity. Similarly, in Addison's disease sodium wasting and isotonic depletion of extracellular volume precede the relative retention of water and development of hyponatremia. Of interest are the contrasting patterns of weight changes and changes in plasma osmolarity in patients with presumed primary ADH excess (or in normal subjects given pitressin chronically) (1,2) and in patients with primary pulmonary salt wasting(5). In the former group, weight gain and extracellular volume expansion lead to increased sodium excretion and hyponatremia, possibly as a result of a diminished secretion of aldosterone in response to the increase extracellular volume(1,2). On the other hand, the salt-waster demonstrates first loss of weight, sodium, and extracellular volume followed by water retention and plasma hypotonicity (5).

Cerebral disease, not an unlikely possibility in the patient reported here, may present the picture of hyponatremia, which from the recent work of Carter and others⁽⁷⁾ appears also to be a result of primary water retention related to excessive ADH secretion.

The data reported here are inadequate to establish the sequence of events in the development of the observed hyponatremia because of the inability to control dietary intake or to obtain accurate weights. It is noteworthy that restriction of water intake rather than the administration of extra salt was the more effective means of correcting the lowered serum sodium concentration.

Summary

A case is reported of a 47 year old white man, terminally ill with presumed carcinoma of the lung, in whom severe hyponatremia associated with persistent urine hy-



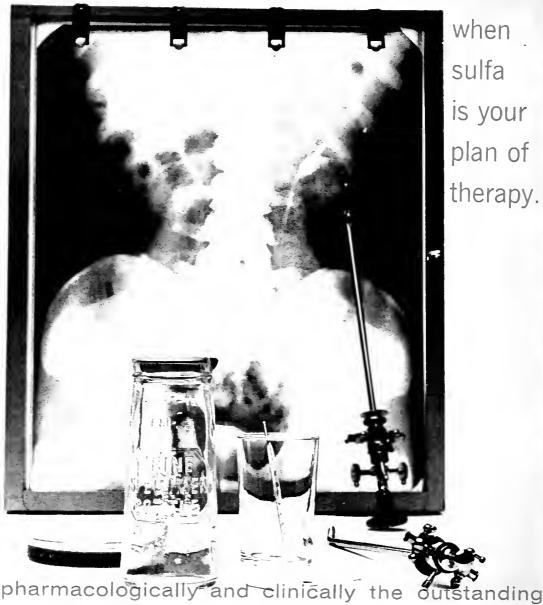
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1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.; Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



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pertonicity developed. Possible explanations for the fluid and electrolyte abnormality are discussed; although pulmonary saltwasting with secondary water retention cannot be excluded with certainty, it appears likely that the hyponatremia resulted from a persistent and "inappropriate" secretion of anti-diuretic hormone. It should be emphasized that patients presenting this type of defect in water metabolism can best be managed therapeutically by simple restriction of water intake.

References

 Schwartz, W. B., Bennett, W., Curelop, S., and Bartter, F. C.: A Syndrome of Renal Sodium Loss and Hyponatremia Probably Resulting from Inappropriate Secretion of Anti-Diuretic Hormone, Am. J. Med. 23:529-542 (Oct.) 1957.

- Bartter, F. C.: The Role of Aldosterone in Normal Homeostasis and in Certain Diseases States, Metabolism 5:369-383 (July) 1956.
- (a) Berliner, R. W., and Davidson, D. G.: Production of Hypertonic Urine in the Absence of Pituitary Antidiuretic Hormone, J. Clin. Investigation 36:1416-1427 (Oct.) 1957. (b) Kleeman, C. R., Maxwell, M. H., and Rockney, R.: Production of Hypertonic Urine in Humans in the Probable Absence of Antidiuretic Hormone (ADH). Proc. Soc. Exper. Biol. & Med. 96:189-191 (Oct.) 1957.
- Gaunt, R., Birnie, J. H., and Eversole, W. J.: Adrenal Cortex and Water Metabolism. Physiol. Rev. 29:281-310 (Oct.) 1949.
- Sims, E. A. H., and others: Asymptomatic Hyponatremia in Pulmonary Tuberculosis, J. Clin. Investigation 29:1545-1557 (Nov.) 1950.
- Leaf, A., and Mamby, A. R.: An Antidiuretic Mechanism Not Related to Extracellular Fluid Tonicity, J. Clin. Investigation 31:60-71 (Jan.) 1952.
- Carter, N. W., Rector, F. C., Jr., and Seldin, D. W.: Pathogenesis of Persistent Hyponatremia with Water Retention in Cerebral Disease, Clin Res. 7:273 (April) 1959.

The Treatment of Superficial Fungus Infections of the Skin With Oral Griseofulvin*

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KENNETH BLAYLOCK, M.D.
DURHAM

Griseofulvin was isolated in 1939 by Oxford, Raistrick and Simonet⁽¹⁾, and in 1946 Brian, Curtis, and Hemming⁽²⁾ described a "curling factor" isolated from a penicillium, which characteristic was later identified and the chemical structure of griseofulvin established by Grove, MacMillan, Mulholland and Rogers⁽³⁾. It was not until 1958, however, that Gentles⁽⁴⁾ reported the effectiveness of griseofulvin in animals experimentally infected with *Microsporon canis* and *Trichophyton mentagrophytes*.

Griseofulvin has been isolated from at least four strains of penicillium, and occurs as a white, bitter, neutral, thermostable chemical compound with a chemical formula of 7-chloro, 2'4, 6-trimethoxy-6'-methyl spiro (benzofuran-2(3H), 1'-(2) cyclohexene)-3, 4'-dione.

The first enthusiastic clinical reports in human beings by Williams, Marten and Sarkomy⁽⁵⁾, by Blank and Roth⁽⁶⁾, and by Rhiel⁽⁷⁾ have been followed by numerous reports by Pardo-Costello⁽⁸⁾, and associates⁽⁹⁾, McCuistion and associates⁽¹⁰⁾, and others. In October of 1959 an International Conference on Griseofulvin was held in Miami, with representatives from all over the world reporting on clinical and laboratory studies.

Since griseofulvin was made available to us in December, 1959, we have treated and

From the Division of Dermatology, Department of Medicine, Duke University School of Medicine and Duke University Medical Center, Durham, North Carolina.

[•]The Griseofulvin used in this study was supplied as Grifulvin by Johnson and Johnson, New Brunswick, New Jersey and its subsidiary, McNeil Laboratories, Inc., Philadelphia, and as Griseofulvin (Ayerst) by Ayerst Laboratories, New York.

Table I

No Pat		Clinical Diagnosi		Organism Cultured	Result
10	Tinea	capitis	M.	andonini	Excellent
3	Tinea	capitis	М.	canis	Excellent
2	Tinea	capitis	Μ.	tonsurans	Excellent
2	Tinea	barbae	Т.	mentagrophytes	Excellent
7	Tinea	corporis	Т.	rubrum	Excellent
1	Tinea	corporis	E.	floccosum	Excellent
1	Tinea	corporis	Μ.	canis	Excellent
14	Tinea	nianum	T.	rubrum	Excellent
12	Tinea	cruris	Т.	rubrum	Excellent
3	Tinea	cruris	E.	floccosum	Excellent
2	Tinea	cruris	T.	mentagrophytes	Excellent
9	Tinea	unguium	T.	rubrum	Good*
12	Tinea	pedis	T.	mentagrophytes	Good
8	Tinea	pedis	T.	rubrum	Good
		-			

*Improvement in all patients treated, although not all patients are "cured." Fingernails show more rapid improvement than toenails.

followed 86 patients long enough to draw definite conclusions. Other patients are under treatment, but have not been followed sufficiently long to warrant any specific conclusions. No patient was treated in whom a diagnosis of a fungus infection was not proved by culture.*

Dosage

All adults have been treated with a dosage of 1.0 Gm. (250 mg. four times daily) and children have been treated with an approximate dosage of 10 mg. per pound per day.

Results

Examinations of skin lesions with KOH usually become negative in about four weeks. At about the same time fluorescent hairs can be seen growing out so that the diseased hair can be clipped, and growth of apparently normal nail is observed. Age, sex, color or race had no influence on results. "Excellent" results indicate symptomatic improvement, together with absence of a positive KOH, a negative Wood's light examination, and/or negative "Good" results indicate progressive symptomatic improvement as good as or superior to conventional local treatment with comparable KOH and cultural results. Reactions

There has been no recognized evidence of liver, kidney, or hematopoietic damage. No evidence of overgrowth of pyogenic organisms has been observed.

Occasional headache and rare instances of dizziness have been reported. Occasional gastrointestinal complaints, and rare erythema multiforme and urticarial reactions have been observed. In no instance have we felt that the reactions were severe enough to withdraw therapy, although the drug has on occasion been discontinued by the patient. No cross reactions have been seen in patients who were alleged to be sensitive to penicillin. Monilial "overgrowth" has been seen in referred patients previously committed to griseofulvin therapy on inadequate cultural diagnoses (which may well have been monilial infections from the outset).

No complete failure has been observed in any patient in whom a Trichophyton or Microsporon etiology was established by culture. Frequent "failures" have been observed in patients treated for so-called tinea infections in whom a diagnosis was not established by culture (moniliasis, dyshidrosis, nummular eczema, and so forth).

No recognized relapses have been observed in tinea capitis or tinea barbae. Occasional relapse has been seen in tinea corporis and tinea cruris when therapy was discontinued, but response to further treatment has been excellent. Relapse usually occurs in the area originally involved as in a "fixed drug" localization. Frequent relapses have been observed in patients with tinea pedis in whom treatment was discontinued prematurely, with good response after therapy was resumed.

Comment.

The mechanism of action of griseofulvin is not known. It is deposited in the keratin of hair, nails, and in the stratum corneum of the skin. Its fungistatic property father than fungicidal action requires long term therapy. Although drug resistance has been suggested, no conclusive evidence has been demonstrated.

Average glabrous lesions will respond in about three weeks; three to six weeks are required for tinea capitis (Trichophyton infections of the scalp require two to four weeks longer therapy than Microsporon infections); three to six weeks are necessary for hand and feet (some feet lesions take longer); 12 to 20 weeks therapy are necessary for fingernails, and toenails require prolonged treatment for six to nine months.

Since response to therapy depends on the rate of keratinization and desquamation of infected keratinized structures

^{*}Fungus cultures were confirmed by Dr. Norman F. Conant and his associates.

GRISEOFULVIN 111

(hair, nail and skin), one may expect that glabrous skin will respond more quickly than hyperkeratotic skin of palms and soles, hair and nails. It is important, therefore, that the infected hair be clipped as it grows out, and that diseased nail and keratin be removed. It is debatable, however, as to whether or not chemical keratolytics may be helpful or harmful by removing the keratin layer in which griseofulvin is stored.

It appears that the results are best in infections of the scalp, and are somewhat less effective in those affecting the feet. The duration of therapy is much longer for infections of the feet and toenails than for fingernails, hands, groin, and body.

Griseofulvin is ineffective for deep fungus infections, monilial infections, erythrasma and tinea (pityriasis) versicolor.

Before griseofulvin therapy is started on any patient the fungus etiology should be established.

Conclusions

Orally administered griseofulvin appears, on the basis of present clinical evidence, to be the best single therapeutic agent for Trichophyton, Epidermophyton, and Microsporon infections.

Griseofulvin is singularly free of serious reactions.

Treatment in full dosage must be continued until lesions are culturally negative.

Like corticosteroid therapy, griseofulvin cannot change the patient's heritage, which is responsible for the "fungus susceptibility" of certain persons.

References

- Oxford, A. E., Raistrick, H., and Simonart, P.: Studies in the Biochemistry of Micro-organisms: LX. Griseofulvin, C(17)H(17)O(6)Cl, A Metabolic Product of Penicillium Griseo-fulvum Dierckx, Biochem. J. 33:240-248, 1939.
- Brian, P. W., Curtis, P. J., and Hemming, H. G.: Substance Causing Abnormal Development of Fungal Hyphae Produced by Penicillium janczewskii: I. Biographical Assay, Production and Isolation of "Curling Factor," Tr. Brit. Mycol. Soc. 29:173-187, 1946.
- Grove, J. F., and others: Griseofulvin: IV. Structure, J. Chem. Soc., pp. 3977-3987, 1952.
- Gentles, J. C.: Experimental Ringworm in Guinea Pigs: Oral Treatment with Griseofulvin, Nature 182:478-477 (Aug. 16) 1958.
- Williams, D. I.; Marten, R. H.; and Sarkany, I.: Oral Treatment of Ringworm with Griseofulvin, Lancet 2:1212-1213 (Dec. 6) 1958.
- Blank, H., and Roth, F. J., Jr.: Treatment of Dermatomycoses with Orally Administered Griseofulvin, A.M.A.
 Arch. Dermat. 79:259-266 (March) 1959.
- Riehl, G.: Griseofulvin: Peroral Wirkendes Antimykoticum, Hautarzt 10:136 (March) 1959.
- Pardo-Castello, V.; Trespalacios, F., Farinas, P., and Baquero, G. F.: El Tratamiento De Las Micosis Superficiales de la Piel Con Griseofulvin, Publicado en el Boletin de la Sociedad Cubana de Dermatologia y Sifilografia 16:1 (March) 1959.
- Blank, H.; Smith, J. G., Jr.; and Roth, F. J., Jr., & Zaias, N.: Griseofulvin for the Systemic Treatment of Dermatomycoses, J.A.M.A. 171:2168-2173 (Dec. 19) 1959.
- McCuistion, C. H., Jr.; Lawlis, Marjorie G.; and Gonzalez, B. B.: Toxicological Studies and Effectiveness of Griseofulvin in Dermatomycosis, J.A.M.A. 171:2174-2180 (Dec. 19) 1959.

British medicine today is a high peak of achievement. In research, in ingenious experiment, in speculative energy, we can hold a candle to any other country in the world. But those who are paramount in these fields came into medicine before 1948. Will British medicine stand so high ten years hence? Unless we can be sure that it will, or at least create the conditions that make for excellence, then the N.H.S. may a decade from now be a perfect machine manned by an army of uniformed conductors but without a driver. Editorial, Brit. M.J. 2:34 (July 5) 1958.

Before the National Health Service, parents bore the cost of the student's education. Now the State pays. The medical student is selected by examination, and character seems to be ignored. This is a source of weakness which cannot be ascribed to the Service. It is due to the general desire to afford equal opportunities to all. But as dean of a London medical school I found the results of entrance examination extremely fallible. Lord Moran Lessons From the Past, Brit. M.J., National Health Service Supplement.

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February, 1960

MIDWINTER EXECUTIVE COUNCIL MEETING

The midwinter meeting of the Executive Council of the State Medical Society was held at the Carolina Hotel, in Pinehurst, January 13—the day after the Officers' Conference. In spite of the steady downpour of rain, there was a full attendance.

President John Reece's opening address was such a model of brevity that it can be quoted in full:

"We're a long way from home; we've lots to do; let's get going!"

Dr. J. P. Rousseau reported briefly on the national legislative situation. Federal aid to medical schools was fraught with the danger of regimentation, in the opinion of most medical men who had studied the subject. He thought that the Forand Bill was not likely

to pass in its present form, but that there was danger of a watered-down version. Any compromise was undesirable, since it would admit that the principle of the Bill is right.

Dr. Wayne Benton reported for the Committee on Finance that for the first time in some years the Society had a surplus—but not enough to justify a reduction in dues.

Dr. Street Brewer reported that the Hospital Care Association had accepted the terms of the Executive Council in its Board structure, and was now eligible for Blue Shield participation on the same basis as the Hospital Saving Association.

Dr. Theodore H. Mees, of Lumberton, reported that the Committee on Hospital and Professional Relations had carefully investigated a conflict between the Board of Trustees and the staff of the Stanley County Hospital. The Board of Trustees had arbitrarily admitted to membership on the staff an applicant who was not acceptable to the majority of the staff membership. The Committee agreed that the hospital staff was justified in its stand. The Council voted unanimously to approve the action of the Committee on Hospital and Professional Relations, and to send a letter to the Chairman of the Board of Trustees of the Stanley County Hospital and carbon copies to the hospital staff and county society.

The Council voted unanimously to join the constituent state societies of the southeast in a contribution of \$500 each to be used in entertaining the delegates to the June A.M.A. meeting in Florida. Heretofore the annual meeting has been held in larger states and the entertainment was not the financial burden that it would have been for Florida.

Dr. R. D. McMillan, for the Committee on Constitution and By-Laws, recommended a few changes to be voted on at the next meeting of the House of Delegates. This Committee, however, recommended that one proposed Amendment to the By-Laws not be adopted: to elect the same members to serve on the Hospital Saving Association and the Hospital Care Association.

These are the high lights of this midwinter meeting. One of the Society's most faithful members—Dr. Westbrook Murphy of Asheville—was unable to attend. A great many commented on how much he was missed.

REGIONAL CONFERENCE ON AGING

The eighth Regional Conference on Aging sponsored by the Committee on Aging of the American Medical Association Council on Medical Service was held in Atlanta, March 7 and 8. Alabama, Florida, Georgia, North Carolina, South Carolina, and Tennessee were represented. More than 450 were in attendance.

The general subject of the Conference was "Meeting the Challenge of the Added Years." North Carolina was well represented, both in the number attending the Conference and in those taking part on the program.

After addresses on "Medicine's Blueprint for the New Era of Aging," by Dr. Edward L. Williams of Miami, and "Misconceptions About Age: The Basic Challenge," by Dr. John S. Atwater, there were panel discussions on "Meeting the Challenge": (1) "To Society"; (2) "To Family and Individual"; (3) "The Role of Prevention"; and (4) "Preparation for Living." Mrs. Oliver R. Rowe of Charlotte gave a fine talk on meeting the "Challenge to Family." Dr. John R. Kernodle spoke on "Our Personal Challenge: The Key to Tomorrow." Dr. Wingate Johnson was moderator of the panel on Prevention.

The Tuesday morning session was devoted to "Meeting the Challenge in Health Services." Dr. Robert A. Cadmus spoke on "Progressive Patient Care," and Dr. O. David Garvin on "A Rural Home Care Program."

All four of the papers by North Carolinians are to be published in later issues of the NORTH CAROLINA MEDICAL JOURNAL.

The close attention paid by the audience throughout the whole day and a half indicates that they were all much interested. The final "Buzz Session" for questions from the audience with answers by the panel participants lasted for more than an hour and a half, and could have been extended much longer if all questions submitted had been answered.

One listening to the program must have been impressed by the number of "quotable quotes" with which the addresses were studded. Instead of trying to abstract the talks, a few of these quotations will be given: Rev. Harry Fifield, in the Invocation, warned against "making our older citizens well but not welcome." Dr. Edward Williams: "There should be no arbitrary dividing line between the useful and useless." Dr. Atwater: "To think young is to stay young; too many have the 'life is over' complex." Dr. Albert McManus, quoting Alfred Noyes Whitehead: "Retirement at a fixed age is idiotic." Mr. L. C. Butcher, Atlanta: "In our human scrap-pile we have reservoirs of manpower not used." Rabbi Rothschild, Atlanta: "There is a difference between being useful and being used." Professor Harry Dickinson: "If there was ever a time for the precepts of the Golden Rule, this is it." Dr. Rottersman, Atlanta: "Part of the emotional needs of the older person comes from 'old wives' tales,' for example, the false idea that there is a decline in the ability to learn after 20."

Dr. Theodore Klumpp, stressing the importance of exercise: "We are afraid to live for fear of dying." George E. Davis, Ph.D.: "To retire from is tragic; to retire to may give life's greatest satisfaction." Dr. Kernodle: "The will to live can't be prescribed by physicians and obtained from the nearest pharmacy." "Many people as they grow older underestimate their capacities." Dr. W. Vinson Pierce, Kentucky (Member, A.M.A. Committee on Insurance), making the point that the care for needy older patients should begin at the lowest practical community level: "You would not phone General Motors Headquarters for advice about starting your car-you would go to your own garage or service station"; and "The old saying, 'Christianity has not failed-it hasn't been tried; applies to community aid in caring for medical indigents."

One general impression of the Conference was that there was a united sentiment against compulsory retirement age. Much emphasis was rightly placed on exercise and diet and nutrition. No political action was taken, but the opposition to extensive control of medical practice was very much in evidence.

BULLETIN BOARD

Preliminary Program of the

ONE HUNDRED SIXTH ANNUAL SESSION

The Medical Society of the

State of North Carolina

May 7, 8, 9, 10, 11, 1960

RALEIGH, NORTH CAROLINA

Headquarters

Sir Walter Hotel

SATURDAY, MAY 7, 1960

2:00 P.M.-Executive Council Meeting (Business of this session may be continued Sunday morning at 10 o'clock) (Sir Walter Hotel)

SUNDAY, MAY 8, 1960

11:00 A.M.—General Registration opens, Booth (Front Lobby-Reynolds Coliseum) (Society Members, Delegates, Officials, Guests Technical and Scientific Exhibitors will register in this area.) (Auxiliary Members to register at Sir Walter Hotel—Mezzanine)

2:30 P.M.—POSTGRADUATE AND AUDIO-VISUAL PROGRAM-J. Leonard Goldner, M.D., Chairman J. Leonard Goldner, M.D., Chairman and Moderator, Durham
George T. Wolff, M.D., Vice-Chairman and Moderator, Greensboro
Some of the following films will be presented at this time; the others will be shown at the Audio-Visual Program at 9:00 A.M. Monday and at 2:30 P.M. Monday.

1. THE TREATMENT OF CAR-DIAC ARREST—(American Medical Association)

Medical Association)

Medical Association)
2. JUGULAR VENOUS PULSE—
(American Medical Association)
3. RESPIRATORY RESUSCITATION TECHNIQUES—(Dept. of
Army Research, Film Section,
Walter Reed Army Hospital)
4. VERTICAL FRONTIERS—
(Winthrop Laboratories)
5. PHYSICAL EXAMINATION OF

PHYSICAL EXAMINATION OF THE NEWBORN-(Pfizer Laboratories)

6. INTRAMUSCULAR IRON THERAPY-(Lakeside Labora-

7. ENDOSCOPIC DIAGNOSIS OF CERTAIN LESIONS OF THE LOWER BOWEL—(Mayo Clinic)
8. DIAPHRAGMATIC HERNIA

WITH MALROTATION—
Sturgis Grant Productions, Inc.)
9. COMBINED MEDICAL AND
SURGICAL TREATMENT OF
CORONARY HEART DISEASE
—(Maurice S. Mazell, M.D.)

10. CAUSES OF ACUTE ABDOM-INAL PAIN—(H. P. Jenkins, M.D.)

11. ACUTE GALL BLADDER DISEASE-(American Cyanamid Company)
THE RELAXED WIFE—

(Modern Talking Pictures Service, Inc.)

13. RESUSCITATION FOR CAR-

DIAC ARREST-(Squibb Visual Aids)

14. DEVELOPMENT OF THE HEART-(Squibb Visual Aids)

8:00 P.M.—Memorial Service Charles H. Pugh, M.D., Chairman,

presiding Choral Presentation: Rex Hospital Nurse Choir Frederick Stan-ley Smith, Di-

An Address: Rev. James G. Huggin,
Pastor, First Methodist
Church, Gastonia

(Elizabeth Room-Sir Walter Hotel)

MONDAY, MAY 9, 1960

MONDAY, MAY 9, 1960
9:00 A.M.—General Registration opens, Booth
(Front Lobby—Reynolds Coliseum)
(Society Members, Delegates, Officials, Guests, Technical and Scientific Exhibitors will register in this area.)
(Auxiliary Members will register at the Sir Walter Hotel—Mezzanine)
9:00 A.M.—NORTH CAROLINA BOARD OF
MEDICAL EXAMINERS
(Meet for Business and Hearings)
(Sir Walter Hotel)

(Sir Walter Hotel)

9:00 A.M.—Technical Exhibits open (Concourse and Rear Lobby-Reynolds Coliseum)

9:00 A.M.—Scientific Exhibits open (Main Floor Arena (rear)-Reynolds Coliseum)

Oliseum)
9 to 12 Noon—AUDIO-VISUAL PROGRAM
Refer to Audio-Visual Program, 2:30
P.M. Sunday, for list of films
10:00 A.M.—First Meeting of the Annual Meeting
of THE HOUSE OF DELEGATES
of the Medical Society—Donald B.
Koonge M.D. presiding Koonce, M.D., presiding (Agenda will be available) (Main Floor Arena-Reynolds Coliseum)

Invocation: Dr. Thomas J. Youngblood, Jr., Pastor, Hillyer Memorial Christian

Church, Raleigh 12:30 P.M.—House of Delegates Recesses

SECTION ON STUDENT A.M.A. CHAPTERS
Monday, May 9, 6:00 P.M.
Sir Walter Hotel
Mr. Gerald W. Fernald, Chairman, Chapel Hill
Banquet—Student AMA—Courtesy of Medical

Society; (admission by ticket)
Welcome: John C. Reece, M.D., President
Medical Society of the State of North Carolina, Morganton

The Mutual Responsibilities of the Medical Society and the Medical Student as a Future Physician John R. Kernodle, M.D., Burlington

Practical Bacteriology for the Private Physician C. E. Fitzgerald, UNC School of Medicine, Chapel Hill -

- Some Disorders of Bilirubin Metabolism Sellers Crisp, UNC School of Medicine, Chapel
- Franconi's Anemia-9 Cases S. Collins, Duke University School of Medicine, Durham
- Alden Dudley, Duke University School of Medicine, Durham
 Ball Valve Thrombi in The Heart
 Timothy C. Pennell, Bowman Gray School of Medicine, Winston-Salem

ALUMNI LUNCHEONS

- Monday, May 9, 1960, 12:30 P.M. Duke University Medical School Alumni Associa-
- tion Luncheon Talmadge L. Peele, M.D., Secretary, Durham (Dining Room, lower level-College Inn Res-
- taurant) University of Maryland Medical Alumni Association Luncheon
- (Rear Dining Room-College Inn Restaurant) Wake Forest Alumni of Bowman Gray School of Medicine Luncheon
 - College Union-State College Campus
- 2:00 P.M.-HOUSE OF DELEGATES of the Medical Society reconvenes (Main Floor Arena-Reynolds Col-
- iseum) 2:00 P.M.—POSTGRADUATE AND AUDIO-VISUAL PROGRAM
- Refer to Audio-Visual Program, 2:30 P.M. Sunday for list of films 5:00 P.M.—Scientific and Technical Exhibits close (Exhibits under supervision of official watchmen)
- 5:00 P.M.—House of Delegates adjourns Annual
- Meeting Social Hour and Entertainment for 5:30 P.M.-Technical and Scientific Exhibitors (Ballroom—Carolina Hotel) by: Medical Society Music: Entertainment and Dance Larry Elliott Orchestra Introduction by: President John C.
- Reece, M.D. 6:00 P.M.—Social Hour—Medical College of Virginia Alumni (Neuseoco Club—Highway #64 East) (Bus will leave Coliseum at 5:45
- P.M. promptly) 6:00 P.M.—MSSNC Student Scientific Section
- Meeting 6:30 P.M.—MSSNC Student Scientific Section— Dinner honoring Second Annual Meeting MSSNC Student Scientific Section
- 6:30 P.M.—Dinner—Medical College of Virginia Alumni Association (Neuseoco Club-Highway #64 East)

PROGRAM

- Tuesday, May 10, 1960 7:30 A.M.—Dutch Breakfast—Medical Women, Medical Society of State of North Carolina (College Union, State College-Room
- 256-258) 8:45 A.M.—Scientific and Technical Exhibits open (Concourse, Rear Lobby and Main Floor-Reynolds Coliseum)
- 9:00 A.M.-Registration opens, Booth (Front Lobby-Reynolds Coliseum)

FIRST GENERAL SESSION

- Tuesday, May, 10, 1960 (Main Floor Arena-Reynolds Coliseum)
- 9:30 A.M.—Call to Order: John S. Rhodes, M.D., Chairman, Committee
 - on Arrangements
 Invocation: Rev. W. W. Finlator,
 Pastor, Pullen Memorial
 Baptist Church, Raleigh
 Announcements: Secretary
 Rhouse
 - Recognition and presentation of President John C. Reece, M.D., Morganton
- 9:35 A.M.—Recognition of Distinguished Guests
- 9:40 A.M.—Report of Committee on Awards: Bruce B. Blackmon, M.D., Chairman, Buies Creek Recognition and presentation of Moore County, Wake County and Gaston County Awardees: Associates, Committee on Scientific
 - Awards: Wm. O. Beavers, M.D., Greensboro James B. Lounsbury, M.D., Wilming-
 - Raphael W. Coonrad, M.D., Durham Lester A. Crowell, Jr., M.D., Lin-
 - colnton John P. Harloe, M.D., Charlotte Felda Hightower, M.D., Winston-Salem
 - Joseph M. Hitch, M.D., Raleigh Vernon W. Taylor, J., M.D., Elkin Emory Hunt, Consultant, Chapel Hill
- 10:00 A.M.—An Address: Immediate Exacerbation of Psychosis Upon Transfer From A Mental Hospital to a Prison Martin F. Keeler, M.D., Dept. of Psychiatry UNC School of Medi-cine, Chapel Hill
 - (From Section on Neurology & Psychiatry)
- 10:20 A.M.-An Address: Observations on Etiology of Simple Goiter Judson J. Van Wyk, M.D., Dept. of Medi-cine, UNC School of Medicine, Chapel Hill (From Section on In-ternal Medicine)
- 10:40 A.M.-An Address: The Meaning of Curative and Palliative Radiation Walter T. Murphy, M.D., Director Therapeutic Radiology Roswell Park Memorial Institute, New York
- (From Section on Radiology) 11:10 A.M.-An Address: Acute Surgical Conditions Associated with Endometriosis
 - Robert A. Ross, M.D., Professor Obstetrics and Gynecol-
 - UNC School of Medi-cine, Chapel Hill (From Section on Surgery)

11:30 A.M.—An Address: Socio-Economic Aspects of Medical Practice and Medical

Society Affairs Leonard W. Larson, M.D., Member Board of Trustees

American Medical Association, Bismarck, N. D.

12:00 Noon-An Address: Senator Sam J. Ervin,

United States Senate Morganton

tific Section)

12:30 P.M.—An Address: Presentation of best paper selected from Student Section Meeting, Monday, May 9 (From Student Scien-

1:00 P.M.—The Annual Address of the President John C. Reece, M.D., President The Medical Society of the State of North Carolina Morganton

1:30 P.M.—Announcements Adjournment

SEE PROGRAM OF STUDENT SECTION AT CONCLUSION OF MONDAY NOON, May 9th

ALUMNI LUNCHEONS

Tuesday, May 10, 1960, 12:30 P.M. Jefferson Medical Alumni Association Luncheon (Dining Room, lower level-College Inn Restaurant) Raleigh Academy of General Practice Luncheon (Host to North Carolina Academy of General Practice) (Red Wolf Den-Cameron Village. Raleigh) University of North Carolina Medical Alumni Association (College Union—State College Campus) North Carolina Society of Internal Medicine Luncheon-Business Meeting (Ballroom-Carolina Hotel)

SECOND MEETING OF THE HOUSE OF DELEGATES

Tuesday, May 10, 1960, 2:30 P.M. (Main Floor Arena—Reynolds Coliseum) (Agenda will be available)

SECTION ON OBSTETRICS AND GYNECOLOGY

Tuesday, May 10, 2:30 P.M. Donald C. Schweizer, M.D., Chairman, Greensboro Caudal Anesthesia in Private Practice Courtney D. Egerton, M.D., Raleigh

Gas Exchange Across the Placenta Stark Walkoff, M.D., Chapel Hill An Evaluation of Hypnosis in Private Obstetrical Practice

Jack E. Mohr, M.D., Lumberton

SECTION ON NEUROLOGY AND PSYCHIATRY Tuesday, May 10, 2:30 P.M. Charles E. Llewellyn, Jr., M.D., Chairman, Durham

2:30-3:00 p.m.-The Concept of Symbiosis and

the Psychotherapy of Schizophrenia Martin H. Keeler, M.D. David W. Abse, M.D. Department of Psychiatry, UNC, Chapel Hill

of Psychiatry, Bowman Gray, Winston-Salem 3:00-3:30 p.m.—Somatic Complaints Associated with Depression and Their

Response to Chemo-Therapy Joseph J. Cutri, M.D., Department 3:30-3:45 p.m.—INTERMISSION

3:45-4:15 p.m.—Exhibitionism Robert Smith, M.D.; John Rhoad:
M.D.; Charles E. Llewellyn, Jr.,
M.D., Dept. of Psychiatry, Duke
University Medical Center, Durham
4:15-4:45 p.m.—Significance of High Incidence of

Schizophrenia in Negroes
M. M. Vitols, M.D., Superintendent
Cherry Hospital, Goldsboro
4:45-5:00 p.m.—GENERAL DISCUSSION
BUSINESS MEETING
Inmediate Evacophetics of Psychola Hopp

Immediate Exacerbation of Psychosis Upon Transfer From A Mental Hospital To A Prison Martin H. Keeler, M.D. Department of Psychiatry, University of North

Carolina, Chapel Hill (Before First General Session)

SECTION ON RADIOLOGY Tuesday, May 10, 2:30 P.M.

Ignacio Bird, M.D., Chairman, Greensboro Complications of Head and Neck Irradiation Walter T. Murphy, M.D., Director

Therapeutic Radiology, Roswell Park Memorial Institute, Buffalo, New York The Plain Film of the Abdomen

Ira E. Bell, M.D., Hickory Radio-Opaque Water Soluble Media in Infants and Children Luther Jarvis, M.D., Gastonia

Cystic Duct Remnants; Their Demonstration and Significance John F. Sherrill, M.D., Durham

Use of Radioactive Isotopes for the Study of Various Aspects of Renal Function Joseph Whitley, M.D.; Richard Witcofski, M.D., I. Meschan, M.D.; and John H. Felts, M.D.,

Winston-Salem

The Meaning of Curative and Palliative Radiation Walter T. Murphy, M.D., Director Therapeutic Radiology Roswell Park Memorial Institute Buffalo, New York

(Before First General Session)

SECTION ON PATHOLOGY Tuesday, May 10, 2:30 P.M.

Bernard F. Fetter, M.D., Chairman, Durham Human Sporotrichosis with Technique for Demon-

stration of Organisms in Tissues

Bernard F. Fetter, M.D., Department of Pathology, Duke Medical Center, Durham

The Use of Acridine Orange as a Screening Technione for Identification of Fungi

Ernest W. Chick, M.D., Veterans Administration

Hospital, Durham

Parasitism by Capillaria Hepatica Simon Calle, M.D., Department of Pathology, Duke Medical Center, Durham

A Group of Uncommon Pulmonary Diseases Sylvaneus Nye, M.D.; W. R. Benson, M.D., De-partment of Pathology, UNC School of Medicine, Chapel Hill The Use and Abuse of Transplantable Tumors in Cancer Research

Chauncey G. Bly, M.D., Department of Pathology, Duke Medical Center, Durham

SECTION ON INTERNAL MEDICINE Tuesday, May 10, 2:30 P.M.

Tuesday, May 10, 2:30 P.M.
Charles H. Burnett, M.D., Chairman, Chapel Hill
A Family with Hereditary Goiter: Clinical Studies
Judson J. Van Wyk, M.D., Department of Pediatrics, UNC School of Medicine, Chapel Hill
Studies of Mechanism
James O. Wynn, M.D., Veterans Administration
Hospital, Durham
PANEL DISCUSSION:
Subject: Dialysis
Opening Remarks: Various Aspects of Dialysis;
Short History of Artificial
Kidneys

Kidneys

Ernest Peschel, M.D., Durham Use of Artifical Kidney in Acute Tubular Necrocis William B. Blythe, M.D., UNC Dept. of Medi-

cine, Chapel Hill
Use of Artificial Kidney in Poisonings
John H. Felts, M.D., Bowman Gray, Winston-Salem

Additional Uses of Artificial Kidney: Selected Cases of Chronic Renal Diseases; Intractable Edema; Hepatic Coma

William A. Kelemen, M.D., Charlotte
Concluding Remarks: Role of Artificial Kidney in
Present Day Therapy; Comparison with other Forms of Dialysis

Ernest Peschel, M.D., Durham OBSERVATIONS ON ETIOLOGY OF SIMPLE

GOITER

Judson J. Van Wyk, M.D., Department of Pediatrics, University of North Carolina, School of Medicine, Chapel Hill (Before First General Session)

> SECTION ON SURGERY Tuesday, May 10, 2:30 P.M.

H. Max Schiebel, M.D., Chairman, Durham Acute Abdominal Pain Associated with Vascular Emergencies

Gordon M. Carver, M.D., Watts Hospital, Durham

The Diagnosis and Treatment of Intussusception in Infants and Children

Louis DeS. Shaffner, M.D., Bowman Gray,

Winston-Salem
Diagnosis and Treatment of Acute Diverticulitis of the Colon

Everett Jackson Dunning, M.D., Charlotte Diagnosis and Treatment of Acute Cholecystitis W. W. Shingleton, M.D., Duke University De-

partment of Surgery, Durham Acute Surgical Conditions Associated with Endometriosis

Robert A. Ross, M.D., Professor of Obstetrics and Gynecology, UNC School of Medicine, Chapel Hill (Before First General Session)

5:00 P.M.-Exhibits close

PRESIDENT'S DINNER Tuesday, May 10, 1960 (College Union-State College Campus) 6:30 P.M.—Banquet (admission by ticket only) Toastmaster: Mr. Billy Joe Patton,

Morganton
Invocation: Rev. John S. Brown, Pastor, West Raleigh Presbyterian Church Raleigh

7:30 P.M.—Presentation of Guests 7:40 P.M.—Presentation of President's Jewel: James P. Rousseau, M.D. Winston-Salem

7:50 P.M.—Installation of President-Elect, Amos N. Johnson, M.D., Garland Administration of the Authorized Oath of Office An Address in Acceptance: Amos N. Johnson, M.D., President Address: Louis M. Orr, M.D., President

American Medical Association

Orlando, Florida 8:30 P.M.—Adjourn Banquet Session 9:30 P.M. to 10:30 P.M.—Entertainment and Music:

Jan Garber and Orchestra (Reynolds Coliseum)

11:00 P.M. to 2:00 A.M.—PRESIDENT'S BALL (Reynolds Coliseum) (Jan Garber Orchestra)

SECOND GENERAL SESSION

Wednesday, May 11, 1960 (Main Floor Arena-Reynolds Coliseum)

9:30 A.M.—Convening Session Charles M. Norfleet, Jr., M. D. First Vice-President, Winston-Salem, presiding

Announcements: John S. Rhodes, M.D., Secretary 9:30 A.M.—An Address: A Follow-Up Study of Premature Infants Born in Wake County, 1949-1951-A Preliminary Report Isa C. Grant, M.D. Health Officer, Wake County Health De-

9:50 A.M.—An Address: Some Facts About
Nursing and Nursing
Education in North Carolina Miss Vivian M. Culver, Executive Secretary N. C. Board of Nurse Registration and Nurse Education

CONJOINT SESSION

Raleigh

(Main Floor Arena-Reynolds Coliseum)

10:10 A.M.—Conjoint Session of the North Carolina State Board of Health,
Charles R. Bugg, M.D., Raleigh,
President, North Carolina State
Board of Health, will preside over
this meeting of the Medical Society
of the State Board of Health
Charles R. Rugg M.D. President Charles R. Bugg, M.D., President J. W. Roy Norton, M.D., State Health Director

RECONVENING SECOND GENERAL SESSION

(Main Floor Arena—Reynolds Coliseum) Charles M. Norfleet, Jr., M.D., presiding 10:40 A.M.—An Address: Staphylococcic Pul-

monary Infections Capt. George L. Calvy, MC, USN Commanding Officer. Naval Medical Field Research Laboratory Camp Lejeune, North Carolina

(Recipient of the Edward Rhodes Stitt Award, 1958) (Antibiotic Medicine)

11:10 A.M.—An Address by President Amos N Johnson, M.D.

11:40 A.M.-An Address: (to be announced) 12:10 P.M.—Elections: (a) Member (2) Editorial Board North Carolina Med-

ical Journal

12:15 P.M.-Adjourn Second General Session

THIRD GENERAL SESSION Wednesday, May 11, 1960 President Amos N. Johnson, M.D., Garland, presiding

(Main Floor Arena—Reynolds Coliseum)

12:05 P.M.—Recognition of Fifty Year Club and presentation of Fifty Year Club Certificates and Pins

12:15 P.M.—Report of House of Delegates

12:20 P.M.—Unfinished Business

New Business 12:25 P.M.—Installation of Officers elected by 1960 House of Delegates

12:30 P.M.—Remarks by President: Amos N.
Johnson, M.D.
Adjourn Sine Die

12:40 P.M.-Exhibits close

12:40 P.M.—Presentation of Prizes:

Raphael W. Coonrad, M.D., Chairman Committee on Scientific Exhibits to make presentation

ALUMNI LUNCHEONS

Wednesday, May 11, 1960, 12:30 P.M.
North Carolina Blind Commission
Advisory Board Luncheon (East Dining Room-College Inn Restaurant)

1:30 P.M.—EDITORIAL BOARD LUNCHEON

SECTION ON GENERAL PRACTICE OF MEDICINE

Wednesday, May 11, 2:30 P.M.
B. Joseph Christian, M.D., Chairman, Greensboro
THEME: THE RELATIONSHIP OF THE GEN-ERAL PRACTITIONER TO THE IN-DUSTRIAL HEALTH OF THE COMMUNITY, THE STATE AND THE NATION

Why You As A Practicing Physician Should Be Interested In Occupational Health Logan T. Robertson, M.D.

Asheville The Governor's Council on Occupational Health: A Medium Of Cooperative Effort For the Health Of The Worker

William P. Richardson, M.D.

Chapel Hill Part-Time Industrial Practice: A Typical Day; A Typical Program

Mac Roy Gasque, M.D.

Pisgah Forest

PANEL DISCUSSION

THE OBLIGATION OF THE PRACTICING PHY-SICIAN FOR THE HEALTH OF THE WORKERS

OF HIS COMMUNITY
Discussants: Logan T. Robertson, M.D., Asheville
William P. Richardson, M.D.,

Chapel Hill Mac Roy Gasque, M.D., Pisgah Forest

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Wednesday, May 11, 2:30 P.M. Carl N. Patterson, M.D., Chairman, Durham SYMPOSIUM ON MIDDLE AND INNER EAR DISEASES

Classification and Medical Management Speaker: William R. Hudson, M.D., Winston-Salem

Discussant: John R. Ausband, M.D., Winston-Salem

II. Surgical Management

Speaker: Sender Stolove, M.D., Durham
Discussant: Ralph A. Arnold, M.D., Durham
HI. Practical Results of Current Surgical Methods
Panel: Moderator—Carl N. Patterson, M.D. Durham

Participants-E. Hale Thornhill, M.D. Raleigh Newton D. Fischer, M.D. Chapel Hill Beverly W. At M.D., Charlotte Armstrong,

SYMPOSIUM ON GLAUCOMÁ

Classification and Diagnosis R. Winston Roberts, M.D., Winston-Salem

Medical Management

Alan Davidson, M.D., New Bern

III. Surgical Management Larry Turner, M.D., Durham

SECTION ON PEDIATRICS Wednesday, May 11, 2:30 P.M. Eugene B. Cannon, M.D., Chairman, Asheboro

Management of Nephrosis William J. DeMaria, M.D., Duke Hospital,

Durham

The Limp During Childhood Euless R. Troxler, M.D., Greensboro New Cardiac Diagnostic Methods for Infants Herbert S. Horned, Jr., M.D.; William H. Sprunt, M.D.

N. C. Memorial Hospital, Chapel Hill Automobile Run-Over Accidents in Children Eben Alexander, Jr., M.D., Bowman Gray, Winston-Salem

> SECTION ON PUBLIC HEALTH AND EDUCATION

Wednesday, May 11, 2:30 P.M. Charles M. Cameron, Jr., M.D., Chairman, Chapel Hill

Universal Specialty: The Private Practice of Occupational Health William L. Wilson, M.D., Occupational Health Section. State Board of Health, Raleigh

An Outbreak of Unusual Water Borne Illness in

Wayne County:
The Local Community Aspects
Arthur S. Chesson, Jr., M.D. Wayne County Health Department

Goldsboro The Epidemiological Aspects Jacob Koomen, M.D. Division of Epidemiology State Board of Health

Raleigh

BULLETIN BOARD

BUSINESS SESSION A Follow-Up Study of Premature Infants Born in Wake County, 1949-1951, A Preliminary Report Isa C. Grant, M.D.; Ellen J. Preston, M.D. Wake County Health Department, Raleigh (Before Second General Session)

SECTION ON ANESTHESIA Wednesday, May 11, 2:30 P.M. Sara J. Dent, M.D., Chairman, Durham Endotracheal Intubation and Complications in the

Pediatric Patient
Doris C. Grosskreutz, M.D., Associate Professor
Division of Anesthesiology, UNC Medical School, Chapel Hill

Body Temperature Control of the Pediatric Pa-tient Under Anesthesia and Post Anesthesia Michel Bourgeois-Gavardin, M.D., Director Department of Anesthesia, Watts Hospital, Durham

Fluid and Electrolyte Balance of the Anesthetized Pediatric Patient

Kenneth D. Hall, M.D., Assistant Professor Department of Anesthesia, Duke Medical Center, A ten-minute question period will follow each talk.

SECTION ON ORTHOPAEDICS AND TRAUMATOLOGY

Wednesday, May 11, 2:30 P.M.
Thomas B. Dameron, Jr., M.D., Chairman, J.
TOPIC: CARE OF INJURED CHILDREN Raleigh The Treacherous Ten Degrees in Football Knees Wayne S. Montgomery, M.D., Asheville Epiphyseal Fractures

H. Robert Brashear, Jr., M.D., Chapel Hill
The Anesthesia of Children with Fractures
C. Ronald Stephen, M.D., Durham
The Soft Tissue Complications of Fractures in the Upper Extremities

J. Leonard Goldner, M.D., Durham Cervical Injuries in Children H. Frank Forsyth, M.D., Winston-Salem

THIRTY-SEVENTH ANNUAL MEETING OF THE AUXILIARY TO THE MEDICAL SOCIETY OF THE STATE OF

NORTH CAROLINA Convention Headquarters: Sunday, May 8 to Wednesday, May 11 Hotel Sir Walter

Sunday, May 8, 1960 Memorial Service Mrs. William P. Richardson 8:00 P.M. Music: Rex Hospital Nurse Choir (Elizabeth Room)

Monday, May 9, 1960 9:00 A.M. to 4:00 P.M. R Registration (Mezzanine)

9:00 A.M. Gold Tournament (Carolina Country Club)

Finance Committee Meeting President's Suite 9:15 A.M.

10:00 A.M. Coffee Hour (Budleigh Room)

Executive Committee Meeting 10:00 A.M.

(Manteo Room) Board of Director's Meeting 11:00 A.M. (Manteo Room)

President-Elect's Luncheon Mrs. Joseph M. Hitch, presiding 12:30 P.M. (Elizabeth Room)

1:00 P.M. General Luncheon (Raleigh Room) Bridge (Elizabeth Room) Tuesday, May 10, 1960

9:00 A.M. to 4:00 P.M. Registration (Mezzanine)

House of Delegates Meeting Mrs. Robert L. Garrard, presiding (Virginia Dare Room) 9:00 A.M.

Intermission for Coffee and Cokes 10:15 A.M. (Budleigh Room)

Annual General Meeting Mrs. Robert L. Garrard, presiding 10:30 A.M.

(Virginia Dare Room) Installation of Officers 11:45 A.M.

(Virginia Dare Room) Luncheon and Fashion Show 1:00 P.M. Honoring Mrs. Frank Gastineau and Mrs. John M. Chenault (Carolina Country Club) (transportation furnished)

4:00 to 5:00 P.M. Tea at Governor's Mansion Members and Guests invited (transportation furnished)

President's Dinner 7:00 P.M. (College Union-State College Campus)

9:30 P.M. Entertainment (Reynolds Coliseum)

President's Ball 10:30 P.M. (Reynolds Coliseum) Wednesday, May 11, 1960

9:30 A.M. to 12:00 Noon Registration (Mezzanine)

Tour of Art Museum (Guides furnished) 10:00 A.M.

COMING MEETINGS

First Physicians Institute on Alcoholism-University of North Carolina School of Medicine, Chapel Hill, April 6 (2:00-6:00 p.m., followed by dinner and reception).

New Hanover County Medical Symposium-Cape Fear Country Club, Wilmington, April 8.

Medical Society of the State of North Carolina, One Hundred Sixth Annual Session-Raleigh, May

North Carolina Pediatric Society, in collaboraion with the South Carolina and Virginia Pediatric Societies, Seminar Cruise to Bermuda-May 21-26; North Crolina Pediatric Society, Annual Meeting -Sedgefield Inn, Greensboro, November 11-12.

Duke University School of Medicine, Fifth Medical Seminar Cruise-Sailing from Wilmington, June 5, and from New York City, June 8; terminating in Hamburg, Germany, June 28.

American College of Obstetricians and Gynecologists, Eighth Annual Meeting-Cincinnati, April

American Medical Association, 1960 Annual Meeting-Miami Beach, Florida, June 13-17.

NEW MEMBERS OF THE STATE SOCIETY The following physicians joined the Medical Society of the State of North Carolina during the month of February:

Dr. David James Stump, 1801 Pineview Street, Raleigh; Dr. Barbara Maynard Moore, 2109 Clark Avenue, Raleigh; Dr. Robert Eugene Sandy, 220 East Main St., Washington; Dr. James Turner Googe, 335 Grand Blvd., Boone; Dr. George Frankl, 923 Arbor Road, Winston-Salem; Dr. Frank Christian Griess, Jr., 1041 Watson Avanue, Winston-Salem; Dr. Robert Lee Johnston, Highlands Hospital, Highlands.

Dr. William Lenoir Wilson, 114 Byron Place, Raleigh; Dr. Augustus H. Foster, Post Office Box 583, Elizabethtown; Dr. Robert Theodore Lucas, Jr., 412 N. Church Street, Charlotte 2; Dr. Katherine Rose Melton, 2912 Crosby Street, Charlotte 7; Dr. Stacy Allen Duncan, Jr., 306 W. Edgerton Street, Dunn; Dr. Margareta Johnson Duncan, 306 West Edgerton Street, Dunn; Dr. Claude Earl Steen, Jr., 767 Haywood Road, West Asheville.

Dr. William Neville Gee, Jr., 811 Simmons Street, Goldsboro; Dr. Richard Rockefeller Spahr, 1225 Forsyth Street, Winston-Salem; Dr. Henry Gaylord Cramblett, Bowman Gray School of Medicine, Winston-Salem; Dr. C. G. Payne, 1203 Morgan Drive, Reidsville; Dr. D. King, 216 S. Main Street, Reidsville.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Under the sponsorship of the Student American Medical Association Dr. Mathew Ross, medical director of the American Psychiatric Association, recently spoke at Bowman Gray Medical School. His topic was "Specialism, Superiority and Psychiatry."

On Monday, February 8, Dr. Robert W. Wissler spoke to the Bowman Gray Medical Society on "Problems and Progress in Atherosclerosis Research." Dr. Wissler is professor and chairman of the Department of Pathology at the University of Chicago School of Medicine.

Dr. Eben Alexander, professor of neurosurgery, has just finished a week as visiting professor of neurosurgery at the National Institutes of Health, Bethesda, Maryland. He spoke and participated in conferences and clinics at the Institute of Neurological Diseases and Blindness.

Dr. William H. Boyce, associate professor of urology, was recently elected to the Association of University Surgeons and the Clinical Society of Genito-Urinary Surgeons.

A postgraduate course in obstetrics and pediatrics was held at Bowman Gray School of Medicine on March 15, 16, and 17 under the sponsorship of the Maternal and Child Health Section of the State Board of Health.

The course was designed for general practitioners who assist in the maternal and child welfare programs in the counties of North Carolina.

The first day and a half were devoted to obstetric topics, the second day and a half to pediatrics, with a panel discussion reviewing major problems related to both fields.

Six seniors and three juniors at Bowman Gray have been elected to membership in Beta Chapter of North Carolina of Alpha Omega Alpha. The seniors are Douglass F. Adams of Titusville, Florida, William H. Admirand of Mt. View, New Jersey, Curtis L. Bakken of Hawley, Minnesota, George C. Barber of West Liberty, Kentucky, Gary B. Copeland of Beaufort, North Carolina, and Miss Bee Gatling of Charlotte. The juniors are Charles E. McCall of Lenoir, William J. Spencer of Winston-Salem, and John M. Tew, Jr., of Linden.

On Friday, March 25, the House Staff Chapter of the Bowman Gray School of Medicine Medical Alumni Association held its second annual House Staff Alumni Day.

Dr. William W. Shingleton, professor of surgery at Duke University and a 1943 graduate of Bowman Gray, was guest speaker for the occasion. Scientific papers also were presented by two members of the present house staff; Drs. George C. Barrett and John C. Pruitt.

Former house staff members from North Carolina and several surrounding states attended the affair, which proved to be very successful.

Three of Russia's leading medical scientists recently visited Bowman Gray and spent a day touring the school and its research facilities. The visitors were Dr. Anastasy G. Lapchinsky, director of the Moscow Institute of Experimental Surgical Apparatus and Instruments, Dr. Mikhail M. Tarasov, director of the Sklifosovsky Institute of Research in Moscow, and Dr. E. A. Zotikov, director of the Moscow Institute of Experimental Biology of the Soviet Union Academy of Medical Sciences.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The Duke University School of Medicine is again offering doctors a chance to combine postgraduate study with an overseas vacation by sponsoring its fifth medical seminar cruise.

This year's Duke cruise will take doctors to the Baltic, visiting Le Havre, Cuxhaven, Leningrad, Helsinki, Stockholm, Copenhagen, and Hamburg. The cruise ship, "T. S. Ariadne," which will sail from Wilmington, North Carolina, on June 5 and from New York City on June 8, will terminate in Hamburg, Germany, on June 28. Some of the doctors will remain in Europe for further vacationing.

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while others will return immediately to the United

States by ship or air.

Shipboard lectures will be given on various subjects in medicine, pediatrics, and thoracic surgery. The faculty will be composed of the following members of the Duke staff: Dr. Jerome S. Harris, professor and chairman of the pediatrics department; Dr. Doris Ahlee Howell, associate professor of pediatrics and pediatric hematologist; Dr. Will C. Sealy, professor of thoracic surgery; and Dr. William M. Nicholson, professor of medicine and assistant dean in charge of postgraduate education. Arrangements are also being made for lectures in the medical centers at Leningrad, Helsinki, Stockholm, and Copenhagen.

The medical program has been approved by the American Academy of General Practice for Cate-

gory I Credit.

Further information can be obtained by writing to the director of Postgraduate Education, Duke University Medical School, Durham, North Carolina.

The four-year baccalaureate program of the Duke University School of Nursing has been accredited by the National League for Nursing.

Leading to the Bachelor of Science in Nursing degree, the baccalaureate program was established at Duke in 1953 and the first class to complete the full program was graduated in 1957. Before the current program was initiated, Duke offered a three-year program that led to the Diploma in Nursing.

A statewide conference on academically talented children was held at Duke University, February 25-26.

Planned by the North Carolina Health Council, the meeting was the sixth in an annual series on children with special needs. The series is made possible by the Nemours Foundation of Wilmington, Delaware.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

The annual Conference on Occupational Health was held at the University of North Carolina School of Medicine Thursday, February 4.

Some 60 persons from throughout the state attended the event, which was sponsored by the Governor's Council on Occupational Health.

Three speakers were featured on the morning program. Dr. Newton D. Fisher of the School of Medicine spoke on "Important Considerations in the Relationship of Noise to Hearing Impairment"; S. E. Pihl, acoustical engineer, discussed "Control of Noise in Industry"; and Dr. William L. Wilson, director of the Industrial Hygiene Section of the North Carolina State Board of Health, discussed "Ways in which State Agencies Serve the Health of the Workers."

The afternoon activities consisted of an open session of the North Carolina Occupational Health Council, with a report on the annual Congress on Industrial Health to be held in Charlotte, October 10-12.

Dr. Claude A. Villee, associate professor of biological chemistry at the Harvard University School of Medicine and a former member of the University of North Carolina faculty, delivered the fifth annual Lee B. Jenkins Memorial Lecture at the School of Medicine on February 24.

Dr. Villee spoke on "Metabolic Effects of Adren-

al Cortical Hormones."

Robert H. Bartholomew, public information officer of the University of North Carolina Division of Health Affairs, has been elected a member of the National Association of Science Writers.

He is the only North Carolinian in the association representing an educational institution and is the second member ever to be elected from North Carolina.

Two postgraduate courses in medicine, sponsored by the University of North Carolina School of Medicine, began in March in Hickory-Statesville and in Elkin.

The courses consist of two lectures one day a week over a six-week period.

The first course began at Hickory on March 15 and will be held at Statesville on alternate Tuesdays. The second course started at Elkin on March 16.

The Hickory-Statesville course is co-sponsored by the Catawba-Iredell-Alexander Medical Societies. The course in Elkin is co-sponsored by the Stokes-Surry-Yadkin Medical Societies.

The lectures in Hickory and Statesville are given at 5:00 p.m. and 8:00 p.m. at the country clubs of both cities. The Elkin lectures will be given at 5:00 p.m. and 7:30 p.m. at the YMCA.

The lecturers on these courses, in order of the appearance, are: Dr. Warfield Firor, Johns Hopkins School of Medicine, Baltimore; Dr. Howard F. Root, New England Deaconess Hospital and Joslin Clinic, Boston; Dr. E. W. Busse, Duke School of Medicine; Dr. Mitchell I. Rubin, University of Buffalo School of Medicine; Dr. Stark Wolkoff and Dr. John T. Sessions, Jr., both of the UNC School of Medicine.

Both courses are approved for credit by the American Academy of General Practice for the number of hours attended by the individual physician.

NORTH CAROLINA HEART ASSOCIATION

A list of appointments to the scientific councils of the American Heart Association recently issued reveals that several North Carolina physicians are serving on these national bodies.

Dr. Harold D. Green of Bowman Gray Medical School is a member of the Program Committee of the Council on Basic Science; and a member of both the Program Committee and the Committee on Instrumental Techniques of the Council for High Blood Pressure Research. Dr. Green is a former president of the North Carolina Heart Association and is currently its Research Committee Chairman.

Dr. John G. Smith of Rocky Mount, another former North Carolina Heart Association president and currently chairman of its Fund Raising Committee, is serving American Heart in several capacities: he is chairman of the Nominating Committee of the Council on Community Service and Education, a member of the Nutrition Committee, and on the Executive Committee of this Council. In addition, Dr. Smith is a member of the Executive Committee of the American Heart Board of Directors.

Dr. Merrill Spencer of Bowman Gray Medical School is a member of the Nominating Committee of the Council on Circulation. Dr. Spencer, an Established Investigator of American Heart, is currently chairman of the North Carolina Heart Association's Program and Budget Committee, and a member of its Executive Committee.

Dr. Keith S. Grimson of Duke Medical School is a member of the Committee for Surgery on Hypertension of the Council for High Blood Pressure Research.

Dr. Edward P. Benbow of Greensboro is a member of the American Heart Board of Directors. He is a former president of the state Heart Association and currently chairman of its Community Service and Specialized Programs Committee.

RANDOLPH COUNTY MEDICAL SOCIETY

The Randolph County Medical Society held a dinner meeting at the Asheboro Country Club on February 25. The guest speaker was Mr. James L. Riddle, chairman of the Randolph County Board of Welfare. He presented a discussion of the problems of medical care of welfare patients in Randolph County and ways of better solving these problems.

EDGECOMBE-NASH MEDICAL SOCIETY

The Edgecombe-Nash Medical Society met on March 9 in Rocky Mount. The meeting was held in conjunction with the Edgecombe-Nash Bar Association.

The speaker was Dr. Isaac Taylor from the Memorial Hospital in Chapel Hill, who discussed his trip to the South Pole as a member of the medical team during a recent expedition.

FORSYTH COUNTY MEDICAL SOCIETY

Dr. John C. Reece, president of the North Carolina State Medical Society, was speaker at the monthly meeting of the Forsyth County Medical Society held in Winston-Salem on March 8. He spoke on the work of the State Society.

AMERICAN MEDICAL ASSOCIATION

A "Commission on the Cost of Medical Care," to delve into every phase of medicine where cost or spending is involved, was announced by the American Medical Association recently. An initial grant of \$100,000 was appropriated to launch the study.

Dr. Louis M. Orr, Orlando, Fla., president of the A.M.A., said that American medicine is "tackling the cost problem in order to help people better meet their obligations when illness strikes, and to help clarify the confusion that exists relative to such cost.

"The American Medical Association is well aware that more physician-patient relationships have been strained by a misunderstanding about fees than perhaps any other disagreement. Is such misunderstanding due to lack of frank discussion between doctor and patient, or is there some other reason? A patient has every right to know why he needs treatment or surgery, what it will consist of, and what it will cost—particularly where major services are rendered."

It is hoped, Dr. Orr added, that the study will also provide some sound advice for the consumer on how to get the most benefit from his health dollar.

In conducting this study, the A.M.A. commission will consult economists, health insurers, prepayment plans, hospital representatives, a cross section of patients, and others whose knowledge and opinions will be helpful.

Members of the commission will be announced shortly, and it is expected to be functioning this spring.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists will hold its eighth annual meeting at the Netherland Hilton Hotel, Cincinnati, April

New this year will be the correlated seminars, it was announced by Dr. W. Norman Thornton of Charlottesville, Virginia, chairman of the program committee. Each seminar will consist of four sessions spread over three days, all devoted to the same subject under the same leader, thus allowing complete development of the material presented.

For further information write to Mr. Donald F. Richardson, Executive Secretary, The American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago 3, Illinois,

AMERICAN COLLEGE OF SURGEONS

A grant of \$146,275 by The John A. Hartford Foundation, Inc., of New York, to the American College of Surgeons to inaugurate a program for improving the medical management of the surgical and injured patient has been announced by Mr.

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Ralph W. Burger, president of the Foundation and Dr. I. S. Ravdin, chairman of the Board of Regents of the College.

The new program will permit immediate establishment of pilot projects in selected cities, employment of a field staff to provide personal guidance—both to the public and to the profession—throughout America, and initiation of an evaluation program, all with the primary goal of improving care of the surgical and injured patient.

NATIONAL FOUNDATION HEALTH SCHOLARSHIPS

North Carolina high school and college students who hope to win a National Foundation Health Scholarship must file applications by April 1, 1960, it was announced recently by Mr. William A. Creech, State March of Dimes Chairman. As of this date, the national office has received only 28 applications from North Carolina students.

Fifteen scholarships made possible by the New March of Dimes will be awarded in the fields of nursing, physical therapy, occupational therapy, medical social work and medicine. Each scholarship is worth \$500 a year, or a total of \$2,000 for four years of college training. Awards will be made on the basis of academic record, professional promise, personal qualifications and financial need. Winners may attend any accredited school in the United States.

"Applications for Health Scholarships have been mailed to all accredited high schools and colleges," said Mr. Creech. "They may also be obtained from the local Chapter Chairman of The National Foundation. Winners of these awards will be selected early this summer by a state committee of leading professionals in the health fields."

INTERNATIONAL CONGRESS ON CONGENITAL MALFORMATIONS

The International Conference on Congenital Malformations will be held in London, July 18-22, 1960, under the sponsorship of the National Foundation.

The program of the conference will deal particularly with the incidence of congenital malformations and their relationship to social and medical conditions, the genetic and environmental factors that may be responsible, the normal mechanisms of embryogenesis and the conditions which result in abnormalities, the relationships between mother and fetus during pregnancy, and the obstetrical problems related to deformity.

Further information concerning the conference may be obtained by addressing the secretariat:

Mr. Stanley E. Henwood, Executive Secretary International Medical Congress, Ltd.

120 Broadway

New York, New York

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YALE UNIVERSITY SCHOOL OF MEDICINE

The Yale School of Medicine will celebrate a century and a half of existence on October 28 and 29 of 1960. The occasion will be marked by meetings, exhibitions, and addresses suitable to the occasion.

Other events associated with the sesquicentennial celebration will take place during the academic year 1960-1961. These include an exhibition of medical art at the Yale Art Museum and a scientific meeting to be held in conjunction with the dedication of a new Medical School auditorium.

PAN-PACIFIC SURGICAL ASSOCIATION

The eighth Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, September 27 through October 5 in 1960.

All members of the profession are eligible to register and are urged to make arrangements as soon as possible if they wish to be assured of adequte facilities because of limited space.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

FIFTH INTERNATIONAL POLIOMYELITIS CONFERENCE

In Copenhagen, Denmark, July 26-27 and 28, 1960, the fifth International Poliomyelitis Conference will be held under the sponsorship of the National Foundation and the Danish Infantile Paralysis Association.

Further information concerning the conference may be obtained by writing to the secretariat; Mr. Stanley E. Henwood, Executive Secretary, International Poliomyelitis Congress, 120 Broadway, New York 5, New York.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

A cleanser for contact lenses is contaminated with a potentially dangerous form of bacteria, the Food and Drug Administration warned recently. Persons who wear contact eyeglasses should avoid using a product called Barnes-Hind Wetting Solution, put up in 2-ounce dropper bottles by Barnes-Hind Ophthalmic Products, Inc., Sunnyvale, California. The cleanser has nation-wide distribution. Larger, 1-pint containers are distributed to practitioners who prescribe or distribute contact lenses.

FDA scientists have found the product is non-sterile and they have isolated a bacterium, Pseu-



the "full-range" oral hypoglycemic agent ...safely lowers blood sugar in mild, moderate and severe diabetes, in children and adults

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domonas aeruginosa, in one lot, which can cause blindness. This code bears the number 010159 on the retail package.

FDA said there would probably be no harmful effects from use in a normal, healthy eye but that dangerous infection may occur if any injury or infection is already present.

Efforts are being made by the company and the Government to recall outstanding stocks.

Heart disease, cancer, strokes, and accidents accounted for 71 per cent of all deaths in 1958, according to final data on 1958 mortality released recently by the Public Health Service's National Office of Vital Statistics.

The 1,647,886 deaths that occurred in 1958 gave the nation a death rate of 9.5 per 1,000 population, compared to a rate of 9.6 in 1957.

The death rates for heart disease and cancer in 1958, 367.9 and 146.9 respectively, were slightly lower than the comparable rates in 1957, 369.6 and 148.7. The rate for vascular lesions remained about the same. The death rate for accidents, 52.3, was almost 7 per cent lower than the rate of 56.0 in 1957, with the percentage decrease being slightly lower for motor-vehicle accidents than for all other forms of accidents.

Chiefly as a result of the influenza epidemic of 1957-58, the toll of deaths from influenza and pneumonia remained high in 1958—57,439 deaths,

or a death rate of 33.2 per 100,000 population. The death rate for these conditions in 1958, the second highest in 10 years, was more than 7 percent lower than the rate of 35.8 recorded in 1957.

The National Institutes of Health, the Public Health Service research center at Bethesda, Maryland has announced the award of 20 grants, totaling \$733,143, to support the training of research scientists in basic medical and health-related sciences.

VETERANS ADMINISTRATION

Dr. John Paul North, chief of surgical service at the Dallas, Texas, Veterans Administration hospital and clinical professor of surgery at the University of Texas Southwestern Medical School will become Director of the American College of Surgeons January 31, 1961.

He will succeed Dr. Paul H. Hawley, the director since 1950.

Dr. North, 59, has held his present post at the Dallas VA hospital since 1955 and was chief of surgical service at the VA hospital, McKinney, Texas, from 1946 to 1957.

During World War II, Dr. North was chief of surgical service in the 20th General Hospital, China-Burma-India Theater.

The "Start Low! Go Slow!" dosage pattern with DBI enables a maximum number of diabetics to enjoy the convenience, comfort and satisfactory regulation of oral therapy in:

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"Start Low! Go Slow" means low initial dosage (25 mg., or 50 mg. in divided doses, per day) with small dosage increments (25 mg.) every 3rd or 4th day until blood sugar levels are adequately controlled. Injected insulin is reduced gradually with each increase in D81 dosage. Satisfactory regulation of mild stable diabetes is usually achieved with D81 alone.*

On "Start Low! Go Slow!" dosage, DBi is relatively well tolerated.

Over 3000 diabetics have been carefully studied on DBI daily for varying periods up to three years. No histologic or functional changes in liver, blood, tedneys, heart or other organs were seen.

DBI (N1- β -phenethylbiguanide) is available as white, scored tablets of 25 mg, each, bottles of 100.

*Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

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A new method of nerve and muscle re-education, for patients whose arms are paralyzed as a result of strokes, was reported by the Veterans Administration recently.

Developed by Dr. Harry T. Zankel, chief of physical medicine and rehabilitation at the Durham, North Carolina, VA hospital, the method has been used for 27 patients at the hospital, and found definitely successful in the majority of cases.

It consists of a series of electrical impulses, administered through electrodes on muscles of the arm and forearm, which is combined with exercise.

Dr. Zankel said the S.A.E. treatment should begin early in paralysis of the arms following strokes and should be continued at home after the patient's discharge from the hospital. Because of the simplicity of the method, it can be applied outside the hospital by intelligent non-professional personnel under supervision of a physician, he said.

Classified Advertisements

WANTED: Male psychiatrist; Diplomate or with three years approved training; to join group practice 145-bed approved psychiatric hospital. Salary: \$15,000-\$18,000 first year; \$20,000-\$25,000 second with incentive factor. Write Box 790 care this Journal, Raleigh, N. C.

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DESIRABLE LOCATION for a physician. Contact Godley Realty Company, Mt. Holly Road, Charlotte, North Carolina.



BOOK REVIEWS

Drugs of Choice 1960-1961. Edited by Walter Modell, M.D. 958 pages. Price, \$13.50. St. Louis: The C. V. Mosby Company, 1960.

The multiplication of new drugs during the past decade or longer makes such a book as this an essential for the busy practitioner who has no way of selecting from the flood of new drugs the ones best suited to the needs of his patients. That Dr. Modell has filled these needs is evidenced by the popularity of the first edition (1958-59). Within two years this edition needed extensive revision to bring it up to date. This has been done in excellent manner by the 47 contributors selected by Dr. Modell.

The 42 chapters in the book cover the choice of drugs for almost every medical need that can be thought of. The drugs of choice are discussed concisely and clearly. The book lives up to a sentence in the preface of the first edition: "A practical guide to the selection of the best drug for a particular therapeutic problem." If any better work of the kind has appeared, this reviewer has not seen it. It can be recommended unreservedly to all practitioners for help in selecting from the wealth of material offered them the remedy best suited for a given condition.

One Hundred Years' History of the North Carolina State Board of Medical Examiners: 1859-1959. By Ivan M. Procter, M.D. F.A.C.S., and Dorothy Long, M.A. 87 pages. Raleigh: Board of Medical Examiners of the State of North Carolina, 1959.

This little volume is a valuable contribution to North Carolina medical history. Dr. Procter and Miss Long deserve great credit for the narrative part of the history of the State Board of Medical Examiners. A wealth of information is compressed into only 22 pages. To this hard core of history is added rosters and excellent pictures of the 17 boards, biographical sketches of the first board members, and copies of the North Carolina State Laws concerning the Board of Medical Examiners.

While this history will never be a best-seller, it is one to be treasured for the wealth of information that it contains. It is also a fine example of the printer's art as practiced by Edwards and Broughton.

Medieval and Renaissance Medicine. By Benjamin Lee Gordon. 843 pages. Price, \$10.00. New York: Philosophical Library, 1959.

The general impression given by this book is that of a fire sale—a few usable items which must be sorted out of an unclassified host of goods in various stages of preservation. There is no dis-

BOOK REVIEWS 127

ernible plan to the work, although for the most art it is a mixture of brief biographies and short istories of disease. A few things seem to have ust been thrown in for good measure, such as a hapter on the history of spectacles, and an exloration of Russian superstitions. There is little alance, with Harvey receiving roughly three ages while many lesser lights get a longer treatnent of their far less significant contributions. The chronologic limits of the title are only genral, with a plate from an edition of Mundinus 1494) sharing space with a silhouette of Dr. Bennett, who performed the first caesarean secion in the United States. Several plates of people vith their calvarie removed are labeled "Vesaius," bu one finally get to an intact Veslius himself.

To those with an interest in this period of medizine the book is useful for some of the bibliographic material, and for the author's opinions on Jewish contributions to medicine. He has a sense of humor, and comments on some things that might well not occur to most of us. But it is an untidy work, and should be bought with that in mind.

Textbook of Otolaryngology. By David D. De Weese, M.D. and William H. Saunders, M.D. 464 pages. Price, \$8.75 St. Louis: The C. V. Mosby Company, 1960.

In the field of otolaryngology there are at present a number of excellent books of the "textbook" or "fundamentals" type. Most of those in general use today are constantly being revised and kept up to date. Nevertheless, a new one has appeared on the scene. The reader's attention is "drawn to the new concepts of diagnosis, treatment, and rehabilitation which, in the last two and a half decades, have broadened the scope of the specialty." Thus, in addition to discussions of the usual diseases of the pharynx, larynx, tracheobronchial tree, esophagus, nose, and ear, there are discussions of speech disorders, the facial nerve, the salivary glands, and correlation of disease states and operative procedures with the anatomy and physiology of the ear.

The text is clear and concise and is accompanied by 354 illustrations. At the end of each chapter is a list of selected readings, including publications by leading otolaryngologists both in this country and abroad. The listed materials are up to date and timely in every instance.

From the technical standpoint the type is clear and the reproduction of the photographs and figures is excellent.

In spite of the fact that this book is one of a growing list of similar works, the high quality of its content and typography should make it highly acceptable and useful, particularly to the medical student, as a textbook of otolaryngology, the basic reason for its existence.

The Month in Washington

Congress appears headed for a showdown this session on legislation for the Federal government to provide medical care for aged persons.

The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several state medical societies planned to send delegations to Washington to personally express their opposition to their Congressmen.

Pressure behind such legislation began to build up early in February.

The Eisenhower Administration announced it was working on three possible programs for providing health care for aged persons in cases of catastrophic—lengthy and costly—illness.

Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to ... make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, Secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The HEW Secretary said consideration also was being given to (1) stepped-up Federal assistance under the federal-state public assistance program, and (2) the federal government supplementing voluntary insurance programs.

Flemming again expressed opposition to the Forand bill which would increase Social Security taxes by one quarter of one percent each on employers and employes to provide hospitalization, surgical benefits and nursing home care for Social Security beneficiaries. The Secretary said he wanted to "underline that the position of the administration is opposition to the Forand bill."

Flemming said he hoped to have an administration bill ready to submit in early

April to the House Ways and Means Committee where the Forand bill is pending. The Committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand bill — which is vigorously opposed by the American Medical Association and allied groups—were pointing their campaign toward securing the House Committee's approval of the legislation at that time.

The AFL-CIO, a main supporter of the Forand bill, urged labor union members to write to congressmen on the Committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation, but failed to mention that the overwhelming majority of doctors oppose it.

In Memoriam

Lester C. Todd, M.D.

The death of Dr. Lester C. Todd on December 29, 1959, was a distressing and grievous shock to his many friends.

He is survived by his wife, Mrs. Alice Schlickenmeyer Todd, a son, Lester C. Todd, Jr., a brother, Walter S. Todd, a niece, Mrs. Robert L. Strickland and two grandchildren.

He was born September 6. 1888, in Center Point, Iowa, the son of the Reverend Quintus C. and Mary Ellis Todd. Following his public education, he received an A. B. degree from Tabor College. He served for two years as a supervisor of 25 government schools in the Philippine Islands before entering the University of Michigan Medical School, where he received his M. D. degree in 1918. He became a member of Phi Chi fraternity

at the University and also held membership in Alpha Omega Alpha. He did research for Parke, Davis and Company Laboratories during his summer vacations. On graduation, he entered the U. S. Navy Medical Corps and served until the end of World War I when he was discharged with the rank of Captain.

From military service he came to Charlotte, where he joined the Crowell Clinic and was in charge of all laboratory and pathologic services. He also served as a pathologist to the Charlotte Sanatorium for several years. This experience put him in an unusually advantageous position to take up his specialty of allergy in 1930. He became outstanding in his chosen field, holding positions of trust and offices in several national societies.

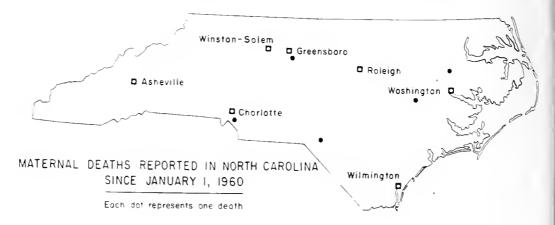
He was a member of his County, District and State medical societies, the American Medical Association, American Academy of Allergy, American College of Allergists, Southeastern Allergy Association, American Society of Clinical Pathologists, Southern Medical Association, and Tri-State Medical Association.

His meticulous attention to detail in his work was a characteristic well appreciated by his medical colleagues. The many medical papers which he published reflect his attention to fine detail and unusual knowledge of the whole of medicine.

He was an active member of Covenant Presbyterian Church, holding the office of Elder at the time of his death. As a charter member of the Charlotte Lions Club, he spent much time working with the blind. His club honored him by making him its first Honorary Life Member.

Lester Todd is gone. His many contributions will perpetuate his name in Mecklenburg medical history. His quiet, sincere personality will linger with his colleagues and many close friends as a delightful memory.

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The first specific aldosterone-blocking agent...

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effectively extends the medical control of edema or ascites. It introduces a new therapeutic principle in the treatment of...

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ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

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ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

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It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

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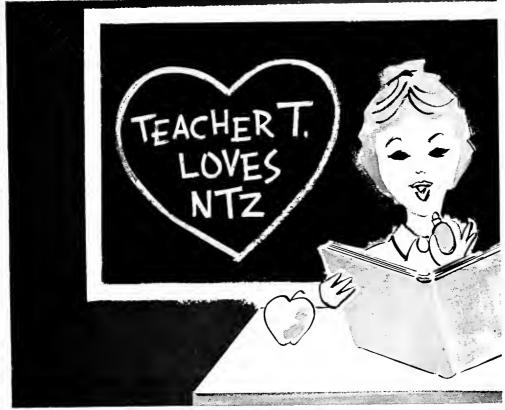
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20 cc. spray bottles; also 1 oz. bottles with dropper

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— unexcelled decangestant—

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Pharmacologically balanced formula for prompt symptomatic relief

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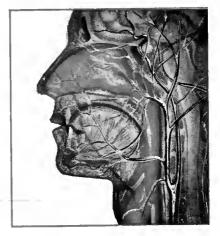
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Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958.
 Lhotka, F. M.: Illinois M. J.: 112:259 (Occ.) 1957.
 Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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timed-release tablets and juvelets also non-alcoholic, fruit-flavored syrup

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51 to 49...it's a boy!





94 to 6 BONADOXIN stops morning sickness

When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male. But when she mentions morning sickness, your course is clear: BONADOXIN.

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BONADONIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis, Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness. See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept, HEW, Vol. 48, No. 14, 1938, p. 398, 2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.



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Pyrilamine Maleate	25-50 mg.	37.5 mg ,	12.50 mg.	33.3%
Chlorpheniramine Maleate	2-4 mg.	3 mg.	1.25 mg.	41.7%
Dose (of the th	ree contai	Combined ined anti- Tristamine	100.0%



Sustained Release Capsules, 60 mg., Bottles of 30, 100 and 1000.

Liquid, 10 mg./5 cc., Bottles of one pint and one gallon.

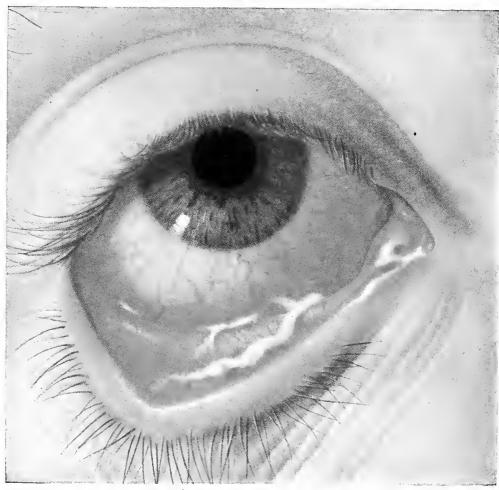
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Tristamine Liquid (10 mg./5cc.)

Adults, two teaspoonfuls four times daily; Children 12 to 16, one to two teaspoonfuls three to 4 times daily; Children 6 to 12, One teaspoonful; Children under six, one-fourth to one-half teaspoonful.





no irritating crystals - uniform concentration in each drop STERILE OPHTHALMIC SQUUTION

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1. Lippmann, O. Arch. Ophth. 57:339, March 1957. 2. Gordon, D.M. Am. J. Ophth. 46:740, November 1958, supplied: 0.5% Sterile. Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile. Ophthalmic Solution HYDELTRASOL*. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic. Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL.

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Acetylsalicylic Acid ... gr. 2½
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*Peterman, R. A.: Clinical report cited with permission.



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a Division of American Cyanamid Company, Pearl River, N. Y

for control of nasal allergies and seasonal hay fever

BRAND OF TIMED DISINTEGRATING ANTIHISTAMINE-DECONGESTANT TABLETS

Each tablet contains:

6.0 mg. Chlarpheniramine Maleate

37.5 mg. Pyrilamine Maleate

15.0 mg. Phenylephrine Hydrachloride

ONE TABLET

swiftly drys up nasal secretions; yields maximum response 10 to 12 hours

One third of the dosage disintegrates immediately to control irritating nasal secretions. The remaining dosage releases gradually to provide a therapeutic effect up to 10 to 12 hours. Only minimum side effects and low pressor.

Two widely proven antihistamines. And, a potent decongestant. Now combined in Animine Timed Disintegrating Tablets.

Prescribe

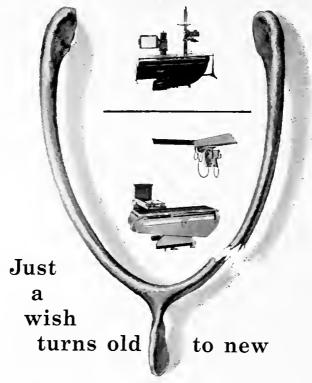
Anamine

Available in bottles SO and 2SO tablets; also pint liquid.

Mayrand inc.

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Greensboro, North Carolina



Modernize without capital outlay on the G-E Maxiservice x-ray rental plan

Think of renting x-ray equipment as conveniently as you subscribe for telephone service! Exclusive Maxiservice rental plan offers all new-model G-E x-ray units . . . takes no capital from your savings. Makes it worryfree to "go modern" in x-ray and always stay that way. For complete details, contact your G-E x-ray representative, listed below.

All this for one monthly fee -

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LIVING PROOF OF FETAL SALVAGE WITH

DELALUM Improved Progestational Therapy



Garden City, N. Y.



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No. Massapequa, L. I., N. Y.



Roselle, Ill.



Seaford, N. Y.



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DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply: Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.



Squibb Quality - The Priceless Ingredient

Diagnostic Quandaries



Colitis? Gall Bladder Disease? Chronic Appendicitis?

Rheumatoid Arthritis? Regional Enteritis?

DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.¹

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.²

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.²

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of Simarouba glauca, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat

suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubinindicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

- 1. Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chrönic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig of Treat (6.1821~(Dec., 1955)).
- 2 Rinehart, R.E., and Marcus, H. Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., 54:708 (July, 1955).
- 3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. θ :897 (June, 1958).

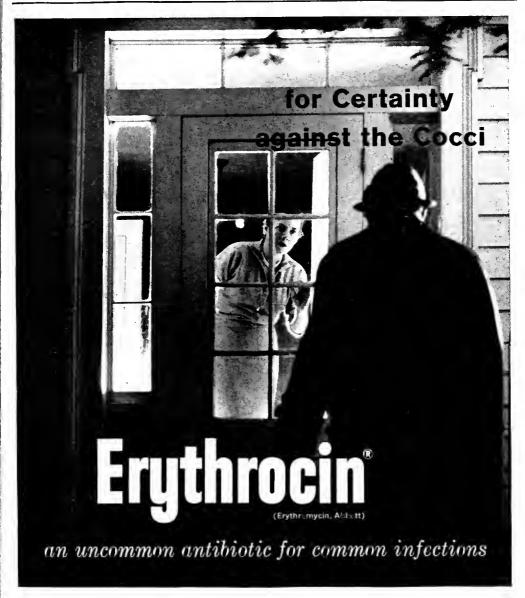
*U.S. Pat. No. 2,864,745

THE S.E. MASSENGILL COMPANY BRISTOL, TENNESSEE

NEW YORK

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SAN FRANCISCO



Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs[®] (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.

AS -- FILE-SEALED TABLETS, ABBOTT, U.S. PAT. NO. 2,881,095



complications

GUSA-ILIRACYDIN CAPSULES

Cosa-Tetracyn® - analgesic - antihistamine compound

act ouickly to

- control secondary infection
- alleviate cold symptoms

each capsule contains:

 Cosa-Tetracyn
 125 mg.

 phenacetin
 120 mg.

 caffeine
 30 mg.

 salicylamide
 150 mg.

 buclizine HCl
 15 mg.

average adult dose: 2 capsules q. i. d.





AN AMES CLINIQUICK

WHY IS DIABETES IN INFANTS SO DIFFICULT TO DIAGNOSE?

Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes 8:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

the standardized urine-sugar test for reliable quantitative estimations



DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms In 110

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	5	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominat cramps	1	0.9
Adapted from Traisman,	H. S.; Boehm,	J. J., and New-

comb, A. L.*

- · full-color calibration, clear-cut color changes
- · established "plus" system covers entire critical range
- · standard blue-to-orange spectrum
- · standardized, laboratory-controlled color scale
- · "urine-sugar profile" graph for closer control







more and more physicians are prescribing this triple sulfa







TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidinee)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood - brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization SUPPLY: Tablets, O.5 gm. • Suspension, raspberry flavored, O.5 gm. per teaspoonful (5cc.).



Squibb Quality—the Priceless Ingredient

Complete local claim service

that's prompt, efficient, satisfactory.



Don't forget that your local American Health Agent...by specializing in your patient's HOSPITAL, MEDICAL and SURGICAL insurance problems—offers extra services of special value to you . . .

He's a specialist—a career man in his chosen field. He has earned a good reputation *locally*, with efficient service and prompt attention to claims.

Moreover, he appreciates the impact that health insurance can have on the practice of medicine, and wants to co-operate with the local medical profession.

AMERICAN HEALTH INSURANCE CORPORATION

300 St. Paul Place, Baltimore 2, Maryland

It makes sense to expect special results from a specialist in the field of health insurance.

Major Hospital Policy

Pays up to \$10,000.00 for each member of your family, subject to deductible you choose

Deductible Plans available:

\$100.00

\$300.00

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Business Expense Policy

Covers your office overhead while you are disabled, up to \$1,000.00 per month

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IN SENILE CONFUSION . . .

CONTINUOUS

CEREBRAL

OXYGENATION

WITH

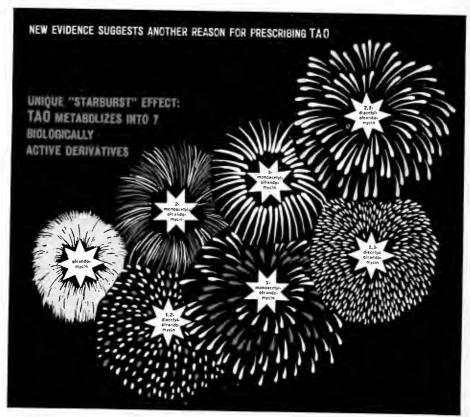
ONE

Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
 Pentylenetetrazol300 mg.
 Nicotinic Acid150 mg.
- Indications: Respiratory and circulatory stimulant for the aged and debilitated patient with symptoms of mental confusion, depression or atheroscleratic psychosis.
- Supplied: Battles of 42 Toblets (3 weeks' treatment)
 - TEMPOTROL (Time Controlled Therapy)

COLUMBUS

PHARMACAL COMPANY Columbus 16, Ohio



The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of in vivo and in vitro biological and biochemical evaluations that show TAO to be indeed unique.1.2

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which remain active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of Staph. aureus.

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%) No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules — 250 mg., and 125 mg., bottles of 60. TAO for Oral Suspension —125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. Prescription only.

Other TAO forms available: TAO Pediatric Orops: flavorful, easy to administer. TAO®-AC: TAO analgesic, antihistaminic compound. TAOMIO®: TAO with triple sulfas. Intramuscular or Intravenous: in clinical emergencies. Prescription only.

 English, A. R., and McBride, T. J.: Proc. Soc. Exper. Blol. & Med. 100:280 (Apr.) 1959.
 2. Celmer, W. O.: Antibiotics Annual 1958-1959.
 New York, Medical Encyclopedia, Inc., 1959, p. 277.
 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8420 (Aug.) 1958.



For the Best Years of Their Lives





NICOZOL COMPLEX

ORIGINAL FORMULA

. Ideal . New Geriatric Tonic Stimulant

NICOZOL COMPLEX is a cerebral stimulant-tonic and dietary supplement intended for geriatric use. Improves mental and physical well-being. Improves protein and calcium metabolism. Indicated during convalescence, also as a preventive agent in common degenerative changes.

Dosage:

1 teaspoonful (5 cc) 3 times a day, preferably before meals. Female patients should follow each 21-day course with a 7-day rest interval.

Supply:

NICOZOL COMPLEX is available as a pleasant tasting elixir. Popularly priced. Bottles of 1 pint and 1 gallon.

Formula

Each 15 cc (3 teaspoonfuls) c	onta	ins
Pentylenetetrazol	150	mg.
Niacin	75	mg.
Methyl Testosterone	2.5	mg.
Ethinyl Estradiol	0.02	mg.
Thiamine Hydrochloride	6	mg.
Riboflavin	3	mg.
Pyridoxine Hydrochloride	6	mg.
Vitamin B-12	2 1	ncg.
Folic Acid	3.33	mg.
Panthenol	5	mg.
Choline Bitartrate	20	mg.
Inositol	15	me.
1-Lysine Monohydrochloride	100	mø.
Vitamin E (a-Tocopherol	100	
Acatata)	3	mσ
Acetate)		

Iron (as Ferric Pyrophosphate) 15 mg.
Irace Minerals as: lodine 0.05 mg.,
Magnesium 2 mg., Manganese 1 mg.,
Cobalt 0.1 mg., Zinc 1 mg.
Contains 15% Alcohol

Write for professional sample and literature.



WINSTON-SALEM 1, NORTH CAROLINA





BUILDING

Food is the source of all body protein . . . the primary building material of all living cells . . . of enzymes which digest and metabolize food and synthesize new body tissue . . . of hormones which regulate growth and body functioning . . . of antibodies which protect from disease . . . even of the genes which determine the characteristics of the individual.

The efficiency with which food proteins are used depends upon the balance of essential amino acids which are simultaneously supplied with sufficient calories from fat and carbohydrate . . . and with needed minerals and vitamins. Not all food proteins, individually consumed, are equally well utilized for building body tissues . . . because food proteins vary in structure . . . in their amino acid content. However, food proteins are seldom eaten individually. Instead, proteins of different foods are combined in meals . . . and the amino acids in each tend to supplement each other . . . as do the other nutrients present.

In A Guide to Good Eating, the foods in the first two groups supply the highest quality protein. In amounts listed, about these portions of the daily protein allowance are supplied by each food group . . .

1/4 from milk, cheese and ice cream . . . 1/3 from the

A GUIDE TO GOOD EATING - USE DAILY DAIRY FOODS

3 to 4 glasses milk—children • 4 or more glasses teenagers • 2 or more glasses—adults • Cheese, ica cream and other milk-made foods can supply part of the mils

MEAT GROUP

2 or more servings . Meats, fish, poultry, eggs, or cheese - with dry beans, peas, nuts as alternates

VEGETABLES AND FRUITS

4 or more servings . Include dark green or yellow vegetables; ortrus fruit or tomatoes

BREADS AND CEREALS

4 or more servings • Enriched or whole-grain added milk improves nutritional values

meat group . . . 1/4 from vegetables and fruits . . . 1/7 from breads and cereals.

When combined in well-prepared meals, foods selected from each of these four food groups can provide adequate protein . . . while satisfying the tastes, appetites and all other nutrient needs of all members of the family . . . young and old.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current outhoritative medical opinion.

Since 1915 . . . promoting better health through nutrition research and education.



NATIONAL DAIRY COUNCIL

A non-profit organization 111 N. Canal Street · Chicago 6, Ill.

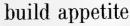
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Winston-Solem 610 Coliseum Drive Winston-Solem, N. C.

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with B complex vitamins



prevent nutritional anemia

with ferric pyrophosphate, a form of iron exceptionally well-tolerated



in taste-tempting cherry flavor

Average dosage, 1 teaspoonful (5 cc) contains:

(0 00.) Contonia.
1-Lysine HCI 300 mg.
Vitamin B12 Crystalline 25 mcgm.
Thiamine HCI (B ₁) 10 mg.
Pyridoxine HCI (B ₆) 5 mg.
Ferric Pyrophosphate (Soluble) 250 mg.
Iron (as Ferric Pyrophosphate) 30 mg.
Sorbitol 3.5 Gm.
Alcohol
Bottles of 4 and 16 fl. oz.



promote protein uptake

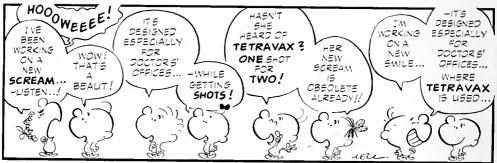
with the potentiating effect of 1-Lysine on low-grade protein foods



FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more diseases...with fewer injections

Supplied: 9 cc. vials in clear plastic cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



Far additional information, write Professional Services, Merek Sharp & Dahme, West Point, Pa.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

Squibb Announces Chemipen

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy

As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored. nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

Tetracycline Phosphate Complex (TETREX®) in the Therapy of

ACUTE PHARYNGITIS, ESPECIALLY WITH LYMPHADENITIS

Ideally, selection of the proper antibiotic for treatment of acute pharyngitis should await the laboratory reports on the susceptibility of the infecting bacteria. But the busy practitioner who sees many patients a day during the upper respiratory infection season may sometimes, find it difficult to avoid the empirical choice of an antibiotic. Unfortunately, this practice may sometimes result in therapeutic failure.

No matter what the pressure of the immediate situation, it is worthwhile to consider taking a bacterial specimen from the infected pharynx for culture and sensitivity studies before starting treatment. Thus, a rational basis will be provided for changing the antibiotic should the first choice prove ineffective.

Which Antibiotic?

All other things being equal, the drug of choice is the one to which the pathogen is most susceptible. But if the exigencies of the situation force the physician to a prompt use of antibiotic, a broad-spectrum preparation that produces immediate high blood levels (e.g., tetracycline phosphate complex, TETREX) probably has the best chance of controlling the pathogen.

Later, the laboratory report frequently may indicate that any one of several antibiotic agents would be equally effective against the particular microorganism in question. In such a case other factors such as frequency and severity of side effects, sensitizing potential and toxicity should be considered.

If the acute pharyngitis in question should be due to gram-negative Klebsiella', penicillin will be of no value, nor will erythromycin be effective. However, this organism is susceptible to tetracycline. If the pathogen should turn out to be gram-positive Streptococcus or Staphylococcus, then penicillin, erythromycin, and tetracycline may all be effective against it.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey it was found that penicillin produced severe skin reactions. But most important was the observation that anaphylactic shock, with a

fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

The tetracyclines (e.g., TETREX) have the advantages of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

Some Microorganisms Susceptible^a to Tetracycline (TETREX)^b

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; C. diphtheriae; B. anthracis; E. coli; Proteus; A. aerogenes; K. pneumoniae; Shigella; Brucella; P. tularensis; H. influenzae; T. pallidum; Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; E. histolytica; D. granulomatosis.

*Some strains are not susceptible.

^bTable adapted from Goodman, L. S., and Gilman, A.: The Pharmaceutical Basis of Therapeutics, 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

High blood, body fluid, and tissue levels of active drug are quickly attained when the new phosphate preparation of tetracycline (TETREX) is used.

The semisynthetic tetracyclines have been in constant use since they were introduced in 1952. They have been proved clinically and have established themselves as safe, effective, and valuable antibiotic agents. But the final decision, the choice of agent, and the control of therapy must remain where it has always been, in the hands of the individual physician.

References: 1. Zinsser, H.: A Texthook of Bacteriology. 11th edition, New York, Appleton-Century-Crofts, 1937, p. 499. 2. Weich, H.: Lewis, C. H.; Weinstein, H. I., and Boeckman, B. B.: Sever reactions to antibiotics. A nationwide survey. Antibiotic Med. & Clio. Ther. 4:890 (December) 1957.

BRISTOL LABORATORIES
Division of Bristol-Myers Company
SYRACUSE, NEW YORK

Tofranil®

In the treatment of depression Tofrānil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases. ¹⁻⁷

Tofrānil is well tolerated in usage is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofrānil

a potent thymoleptic... not a MAO inhibitor.

Does act effectively in *all* types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

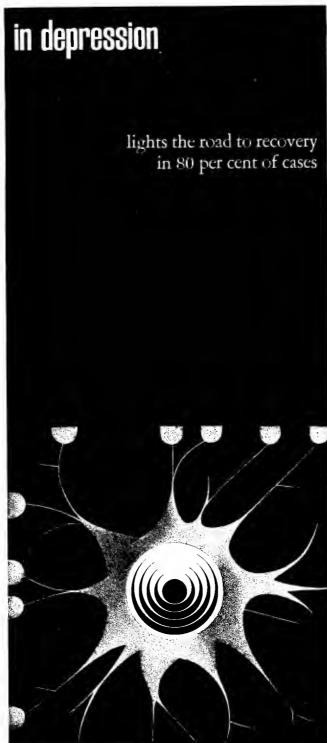
Detailed Literature Available on Request.

Tofranil 8 brand of impramine HCl: tablets of 25 mg., bottles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, cartons of 10 and 50.

References: 1. Ayd, F. J., Jr.: Bull. School Med., Univ. Maryland 44:29, 1959. 2. Azıma, H., and Vıspo, R. H.: A.M.A. Arch. Neurol. & Psychiat. 81:658, 1959. 3. Lehmann, H. E.; Cahn, C. H., and de Verteuil, R. L.: Canad. Psychiat. A. J. 3:155, 1958. 4. Mann, A. M. and MacPherson, A. S.: Canad. Psychiat. A. J., 4:38, 1959. 5. Stoane, R. B.: Habib, A., and Batt. U. E.: Canad. M.A.J. 80:540, 1959. 6. Straker, M.: Canad. M.A.J. 80:540, 1959. 7. Strauss, H.: New York J. Med. 59:2906, 1959.

Geigy, Ardsley, New York







Smooth,

Saxtained Analgesia

ANADOL

EACH TABLET CONTAINS:

Phenobarbital V4 gr.
Warning-May be habit forming.
Acetaminophen 2½/2 gr.
Salicylamide
Hyoscyamine
Sulfate
Acropine Sulfate
Scopolamine
Hydrobromide
Noo002 gr.
0.0008 gr.

ANADOL #2 (Pink)

¼ gr. Codeine ANADOL #3 (Yellow)

½ gr. Codeine

Anadol Tablets are designed to provide the maximum relief from pain possible without resorting to the opiate drugs. The analgesic effect of Anadol is achieved by a unique combination of acetaminophen and salicylamide. Together they form a team that produces a smooth analgesia lasting longer than either drug would provide alone. The presence of phenobarbital potentiates the analgesic effect and provides a moderate degree of sedation. The central effect of the phenobarbital is augmented by the inclusion of hyoscyamus alkaloids, thus contributing to the allaying of tension which is often a factor to be reckoned with when pain is present in any degree.







NADO

PRODUCTS CO., INC.

How to be Carefree Without Hardly Trying

It really takes a load off your mind... to know that you are protected from loss of income due to illness or accident!

"Dr. Carefree" has no 30-day sick leave ... no Workmen's Compensation...BUT he has a modern emergency INCOME PROTEC-TION PLAN with Mutual of Omaha.



When he is totally disabled by accident or sickness covered by this plan, this plan will give him emergency income, free of Federal income tax, eliminating the nightmare caused by a long disability.

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PROPERTIES

n <u>vitro</u> facts and in <u>vivo</u> findings on new broad-spectrum



PROPERTIES:

reater inhibitory action ...lower daily intake than other tetracyclines

A unique new fermentation product of *Streptomyces aureofaciens*, DECLOMYCIN Demethylchlortetracycline achieves notably greater antibiotic activity against infections^{2,4,7,8,10,14,19,20,24} because of two basic factors: (1) inherent potency, and (2) greater stability in most body fluids.^{15,17,18,27} Actual clinical activity has, in many instances, been better than expected on the basis of *in vitro* sensitivity tests.^{14,18,19}

Broad-spectrum control ... with far less antibiotic

Activity levels of DECLOMYCIN Demethylchlortetracycline are higher than those of previous broad-spectrum antibiotics. Hardier strains of various organisms appear to be somewhat more responsive. Apparently some strains of Pseudomonas, Proteus and A. aerogenes, frequently refractory to therapy, are sensitive to DECLOMYCIN. 7.23,25,26



Sustained peak activity ...greater security of control

Prolonged retention and compatibility of DECLOMYCIN with body fluids provides peak activity between doses. 15,17,18,27 Inhibition of bacteria is more constant.

24-48 hours extra activity...protection against relapse

DECLOMYCIN maintains effective antimicrobial action for one to two days after stopping dosage.^{7,14} Resurgence of a few viable pathogens, with relapse...and low patient defense against secondary bacterial invasion during the first post-therapy days...are largely offset.

PERFORMANCE

Susceptibility Tests

Roberts, M. S., et al.28 New York, N. Y.

Tolerance & Toxicity

Boger, W. P., and Gavin, J. J.² Norristown, Pa.

Gonococcal Infection

Marmell, M., and Prigot, A.20 New York, N. Y.

General Medicine

Lichter, E. A., and Sobel, S.¹⁹ Chicago, Ill.

Respiratory Infection

Perry, D. M., et al.²² Seattle, Wash.

Various Infections

Finland, M., et al.? Boston, Mass.

Pyelonephritis

Vineyard, J. P., et al.29 Dallas, Tex.

Soft Tissue Infection

Prigot, A., et al.26 New York, N. Y. Pre-treatment sensitivity tests in 75 genitourinary patients showed DECLOMYCIN Demethylchlortetracycline to be superior against the large majority of organisms and in no instance inferior to tetracycline. DECLOMYCIN apparently has more effective coverage... several strains of *Proteus* and *A. aerogenes* responded.

Administration of the recommended 600 mg. (4 capsules) daily for 30 days to a small group of elderly patients revealed no hematologic, hepatic and urinary alteration or other abnormal finding. No clinical side effects were observed.

All except two of 63 patients with acute gonorrhea responded promptly to therapy with DECLOMYCIN. Fifteen received 250 mg. q.i.d. for one day, the remainder received 600 or 750 mg. in divided doses over one or two days. No side effects.

One hundred and sixty-nine patients with various infections showed generally equivalent response to four dosage regimens, including the recommended level. Of 29 pneumococcal pneumonias, all recovered with I5 afebrile in 48 hours or less – except a few patients with preterminal underlying disease. All 42 scarlet fever patients recovered with 32 afebrile in 48 hours or less. Other patients also responded satisfactorily with few exceptions. No blood, liver or kidney toxicity found. G.I. side effects occurred in only 2 per cent at the recommended dosage, or less, and were easily reversible.

Good or fair response in 24 of 30 cases of acute bacterial pneumonia, and in all of six cases of acute bronchitis. Side effects occurred at higher dosage but were uniformly absent when dosage was limited to 600 mg. per day.

Eighty patients with various infections were treated with DECLO-MYCIN Demethylchlorietracycline and an equal number with tetracycline. Therapeutic response was indistinguishable between the two groups. However, DECLOMYCIN Demethylchlorietracycline dosage was much lower (50 to 60 per cent of that of tetracycline.) In addition, incidence of side effects with demethylchlorietracycline was only half that experienced with tetracycline.

Therapy with DECLOMYCIN was successful in 12 of 13 patients with pyelonephritis. Sterile cultures were obtained in nine patients within six to 14 days. Among the organisms suppressed were strains of A. aerogenes, E. coli and paracolon bacillus. In most cases, DECLOMYCIN was used jointly with another antibiotic.

DECLOMYCIN was used alone or auxiliary to surgical measures in 150 cases of acute soft tissue infection, mostly ambulatory. Full resolution of infection was achieved in all cases, average length of treatment being six days. Dosage was 600 or 750 mg. daily. Side effects consisted of transitory G.I. disturbances in three cases.



Urinary Infection

Trafton, H. M., and Lind, H. E.28 Brookline, Mass. Clinical response was favorable in a majority of 50 cases of urinary tract infections with relief of symptoms, elimination, or marked reduction, of pyuria and with urine sterilization in some. DECLO-MYCIN Demethylchlortetracycline was administered in one-half to one-third the daily milligram level of related antibiotics, for 8 days.

No significant diarrhea occurred in any case although mild nausea and upper G.I. symptoms were fairly common. Photo-

In 570 treated for a great variety of infections, DECLOMYCIN

was successful in resolving infection or in effecting marked improvement in 81 per cent, after failure of other antibiotics.

toxicity occurred in six cases.

Antibiotic-Resistant Infections

Compilation of reports of 210 clinical investigators.²⁸

Pediatric Infection

Fujii, R., et al.9 Tokyo, Japan

Pediatric Infection

Hall, T. N.¹² San Francisco, Cal.

Pneumonias

Duke, C. J., et al.5 Washington, D. C.

Intestinal & Respiratory Infection

Hartman, S. A.¹³ Sherman Oaks, Cal.

Respiratory Infection

Feingold, B. F.ª San Francisco, Cal.

Various Infections

Compilation of reports of 210 clinical investigators.23

Therapeutic results, elicited in 309 pediatric patients with average daily dosage of 15 mg./kg., were equal to those produced by 30 mg./kg. of buffered tetracycline preparations. Satisfactory results were obtained in 75 per cent. No appreciable side effects when 15 mg./kg./day dosage was not exceeded.

All eight cases of ophthalmic, respiratory or otic infection responded to four to twelve days of DECLOMYCIN therapy (5 recovered, 2 greatly improved, 1 improved). One skin reaction, in a case receiving the higher trial dosage of 7 mg./lb. daily, occurred.

Results were satisfactory in all 32 cases of acute bacterial penumonia, excepting for two caused by non-susceptible organisms. Over half had been complicated by pleural, suppurative, bronchial, or underlying structural lung problems. Dosage was low. No toxicity found. Acceptance and toleration were excellent.

Six cases of g.i. infection (diverticulitis, ileitis, colitis) responded in three to eight days on the lower milligram intake...even after failure in most with sulfa, neomycin or penicillin-streptomycin. Complete recovery was gained in 5 respiratory cases on a shorter schedule; another withdrew with occurrence of thrush. No other side effects were reported.

All 13 upper or lower respiratory infections demonstrated very good response in 2-3 days on recommended dosage. No side effects were reported.

Of 1,904 patients with adequate follow-up treated for a wide diversity of infections, 87 per cent were reported as cured or improved. Most patients received one 150 mg. tablet every 6 hours. Therapy usually was for three to eight days. Side effects, mostly referable to the gastrointestinal tract, occurred in 200 patients.



PERFORMANCE (continued)

Respiratory Infection & Others

Gates, G. E.¹¹ South Bend, Ind.

Pustular Dermatoses

Kanof, N. B., and Blau, S. 16 New York, N. Y.

Surgical Infection

Floyd, R. D., and Anlyan, W. G. Durham, N. C.

Wound Infections & Others

Meyer, B. S.²¹ Birmingham, Ala,

Topical & Wound Infections

Stewart, J.26 New Orleans, La.

Oral Infection

Arbour, E. F.¹ New Orleans, La

Brucellosis

Chávez, Max, G.3 Mexico, D. F. Of 65 cases, predominantly respiratory infections, but including some of cystitis and cellulitis, 50 had a good response, 12 were fair and three were failures. One of the failures was a case of chronic ulcerative colitis and two were respiratory infections. The only complication was a slight vulvular pruritus and burning tongue occurring near the end of a week's treatment of residual pneumonitis.

Eighty-five per cent of 67 patients responded with excellent or good results on a DECLOMYCIN schedule of one 150 mg. capsule q.i.d. for two to twelve weeks. Three poor responses were related to highly resistant organisms. No pruritus or drug eruptions developed. Only four cases showed nausea or diarrhea in the long therapeutic course.

Successful results were generally obtained in 60 patients given 600 mg. DECLOMYCIN daily (or slightly less) for five to 15 days. No infection developed in the clean or contaminated prophylaxis group. Most frank infections responded...including several refractory to previous antibiotics. No toxicity evidenced. Intestinal toleration was excellent.

Thirty-five cases, chiefly prophylactic, and some traumatic-surgical wound infections were treated usually on one capsule DECLO-MYCIN q.6 h. for two to eight days. Over 80 per cent responded, including one with Pseudomonas etiology. Minor itching or nausea occurred in two; prominent nausea developed in one on a q.4 h. schedule.

Of 21 patients followed, 15 completely recovered, four improved in four to 42 days on 600 mg. daily. Seven had not responded to various other therapies. One had *A. aerogenes* predominance, complicated by Proteus and *E. coli*. Cases were traumatic-surgical-topical infections with some respiratory. One questionable reaction of anemia was encountered.

Of four patients treated, three responded to one capsule DECLO-MYCIN q. 6 h. for three days. No change in one case of chronic proliferating periodontitis. No adverse reactions seen.

All nine patients infected with *Brucella melitensis* were afebrile on fourth or fifth day of DECLOMYCIN therapy and asymptomatic within 15 days. Treatment lasted for 45 days. No relapses occurred. Hepatic, renal, or hematologic toxicity was not seen. Minor or occasional intestinal reactions in some cases did not require discontinuance.



or other organic, chronic or underlying disease, DECLOMYCIN may be vital to successful resolution of infection. Generally in geriatrics, for the same reason,

intolerance and increases the likelihood of an uneventful therapeutic course. Variants of an infecting organism are less likely to survive the high, sustained activity and post-dosage control. Minor or major reverses or "setbacks" during therapy may be avoided. Susceptibility to secondary infection when dosage is

in the average patient - DECLOMYCIN reduces the possibility of gastrointestinal

terminated is counteracted by the "extra-day" activity.

in mixed infections-DECLOMYCIN provides satisfactory control of conditions involv-

IMPORTANCE...

under adverse host conditions - In debility, malnutrition, neoplasm, diabetes,

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ORAL SUSPENSION, $75~{\rm mg.}/5~{\rm cc.}$ teaspoonful (custard flavor) in 2 oz. bottle. Dosage: 3-6 mg./lb./day-divided in 4 doses.

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- 2. Boger, W. P., and Gavin, J. J.: Demethylchlortetracycline: Serum Concentration Studies and Cerebrospinal Fluid Diffusion. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.
- 3. Chávez, Max G.: Therapeutic Evaluation of Demethylchlortetracycline in Human Brucellosis. Ibid.
- 4. Clapper, W. E., and Proper, R.: Sensitivities of Clinical Isolates to Demethylchlortetracycline and Tetracycline, and Demethylchlortetracycline Serum Levels in Patients. To be published.
- 5. Duke, C. J.; Katz, S., and Donohoe, R. F.: Demethylchlortetracycline in the Treatment of Pneumonia. Read at Seventh Antibiotics symposium, Washington, D. C., November 5, 1959.
- 6. Feingold, B. F.: Clinical report, cited with permission.
- 7. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Observations on Demethylchlortetracycline. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.
- 8. Floyd, R. D., and Anlyan, W. G., Clinical report, cited with per-
- 9. Fujii, R.; Ichihashi, H.; Mınamitani, M.; Konno, M.; and Ishibashi, T.; Clinical Results with Demethylchlortetracycline in Pediatrics and Comparative Studies with Other Tetracyclines. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.
- Garrod, L. P., and Waterworth, P.: The Relative Merits of the Four Tetracyclines. Ibid.
- 11. Gates, G. E.: Clinical report, cited with permission.
- 12. Hall, T. N.: Clinical report, cited with permission.
- 13. Hartman, S. A.: Clinical report, cited with permission.
- 14. Hirsch, H. A., and Finland, M.: Antibacterial Activity of Serum of Normal Subjects After Oral Doses of Demethylchlortetracycline, Chlorte-tracycline and Oxytetracycline, New England J. Med. 260:1099 (May 28) 1021.
- Hirsch, H. A.; Kunin, C. M., and Finland, M.; Demethylchlorietracy-cline A New and More Stable Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. Munchen med. Wehnschr. To be published.
- 16. Kanof, N. B., and Blau, S.: Oral Demethylchlortetracycline in the

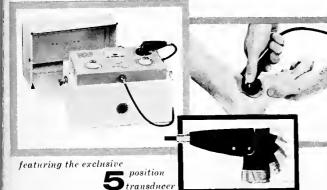
- Treatment of Pustular Dermatoses. Read at Seventh Antibiotic Symposium, Washington, D. C., November 6, 1959.
- 17. Kunin, C. M.; Dornbush, A. C., and Finland, M.; Distribution and Excretion of Four Tetracycline Analogues in Normal Men. *Ibid.*, November 5, 1959.
- 18. Kunin, C. M., and Finland, M.: Demethylchlortetracycline: A New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. New England J. Med. 259:999 (Nov. 20) 1958.
- Lichter, E. A., and Sobel, S.: Scrum Antimicrobial Activity and Clinical Observations in 169 Patients with Demethylchlortetracycline. A.M.A. Arch. Int. Med. To be published.
- 20. Marmell, M., and Prigot, A.: The Therapeutic Value of Demethyl-chlortetracycline in Gonorrhea, Lymphogranuloma Venereum, and Dono-yanosis. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.
- 21. Meyer, B. S.: Clinical report, cited with permission.
- 22. Perry, D. M.; Hall, G. A., and Kirby, W. M. M.; Demethylchlor-tetracycline: A Clinical and Laboratory Appraisal. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.
- 23. Phillips, F. M.: DECLOMYCIN: Seventh Interim Report, Department of Clinical Investigation, Lederle Laboratories, Pearl River, N. Y., December 4, 1959.
- 24. Prigot, A.; Mavnard, A. de L.; and Zach, B.; The Treatment of Soft Tissue Infections with Demethylchlortetracycline. To be published.
- 25. Roberts, M. S.; Seneca, H., and Lattimer, J. K. Demethylchlortetracycline in Genitourinary Infections. Read at Seventh Antibiotics Symposium, Washington, D. C., November 5, 1959.
- 26. Stewart, J.: Clinical Report, cited with permission.
- 27. Sweeney, W. M.: Hardy, S. M.; Dornbush, A. C., and Ruegserger, J. M.: Demethylchlortetracycline: A Clinical Comparison of a New Antibiotic Compound with Chlortetracycline and Tetracycline, Antibiotics & Chemother, 9(13 (Jan.) 1959.
- 28. Trafton, H. M., and Lind, H. E.: Demethylchlortetracycline Effectiveness and Tolerances in Urinary Tract Infections. To be published.
- 29. Vinevard, J. P.: Hogan, J., and Sanford, J. P.: Clinical and Laboratory Evaluation of Demethylchlortetracycline. Read at Seventh Anti-biotics Symposium, Washington, D. C., November 5, 1959.

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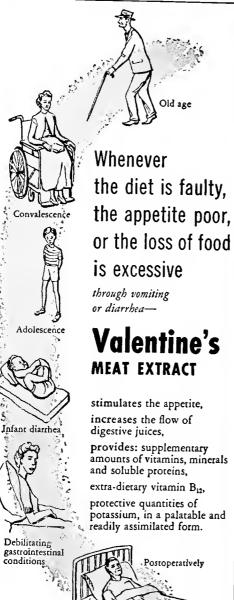
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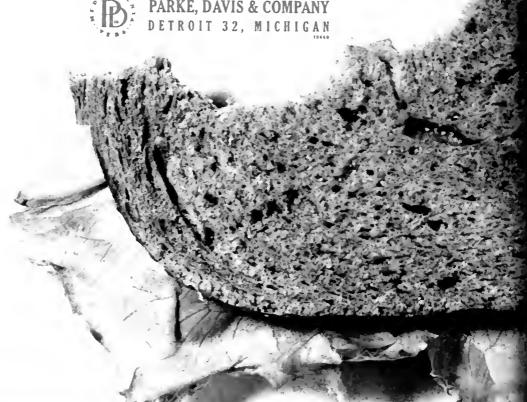
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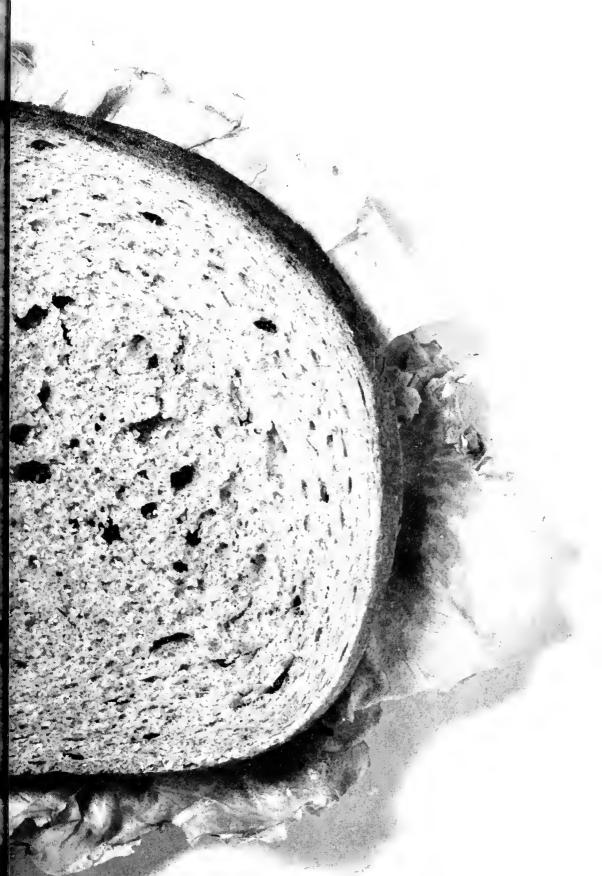
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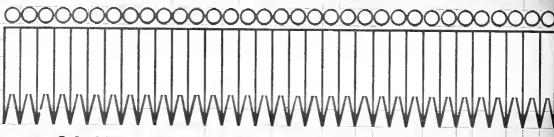
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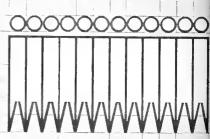
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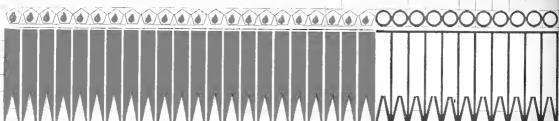
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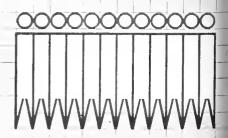


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 Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum, Assoc., San Francisco, Calif., June 21, 1958.
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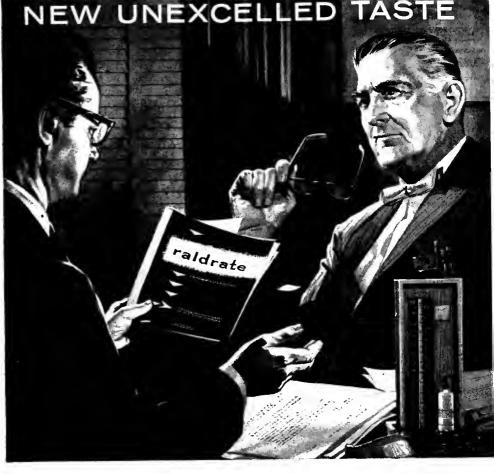
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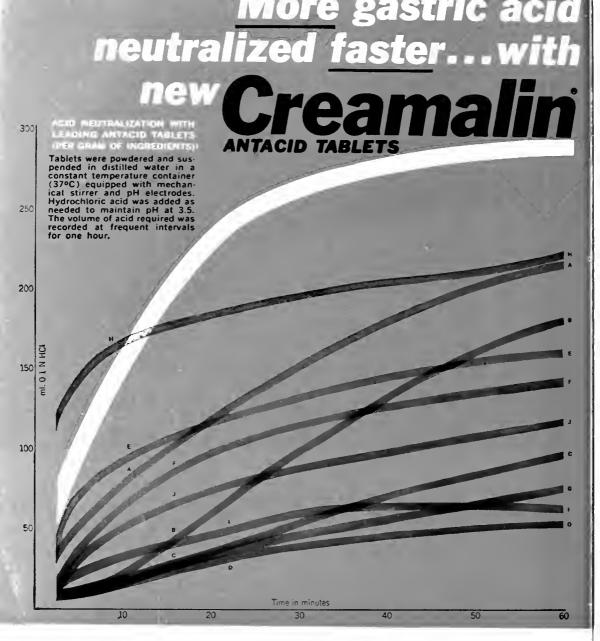
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1. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.; J. Pharm. Exp. Ther. 127:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. 76:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. 76:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpublished reports. 7. Ostrowski, J. P.: Orthopedics 2:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)





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rk J. Med., 53:65, 1953. 5. I. H. Richter, et al., New York J. Med., 51:1303, 1951. 6. C. M. Castro

De Soldati, Angiology, 4:165, 1953. 7. R. M. N. Crosby, Am. J. M. Sc., 225:61, 1953.

sdos and G. E. Arnold, Eye Ear Nose & Throat Month., 38:1035, 1959.

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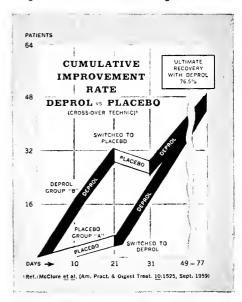
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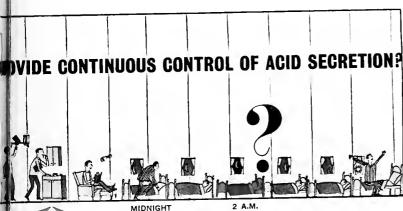
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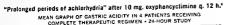
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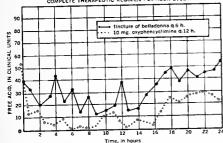
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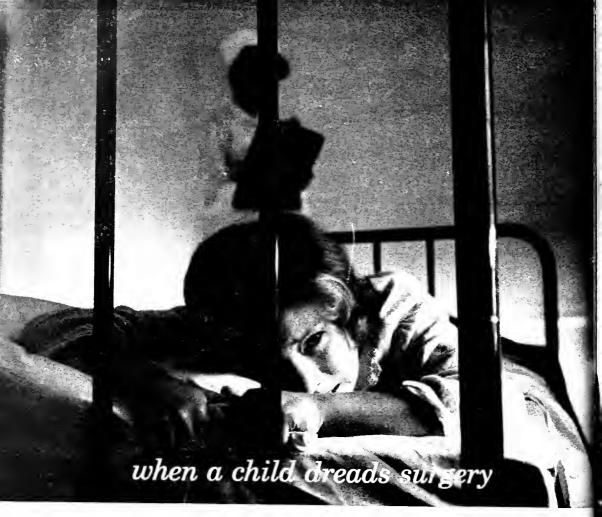
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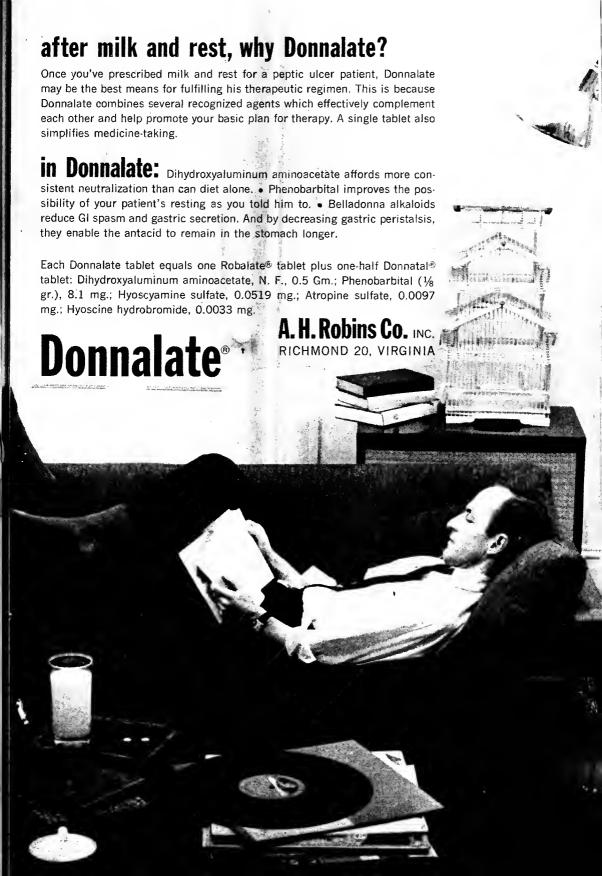
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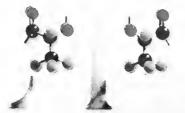
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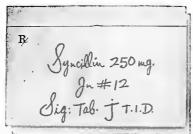
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Significance of complementary action of isomers in SYNCILLIN The antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than that of either of its two component isomers alone against many important pathogens, including some penicillinresistant staphylococci. This phenomenon has been described as *Isomeric Complementarity*.

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Efficacy of SYNCILLIN against staphylococci and other resistant organisms Studies have shown that SYNCILLIN is effective in vitro against a higher percentage of hospital "staph" strains, than penicillin G and penicillin V.^{1,2} Therefore, if clinical judgment indicates the use of penicillin, SYNCILLIN might be expected to be somewhat more effective. However, since some strains are still resistant to SYNCILLIN as well as to the other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment.

There have recently been reports of decreased efficacy of penicillin in streptococcal³ and gonococcal^{4,5} infections. The emergence of penicillin-resistant gonococci appears to be associated with an increase in the incidence of gonorrhea all over the world. When a less sensitive strain is encountered the higher blood levels produced by SYNCILLIN may be most helpful.



major therapeutic advantages accompany molecular asymmetry

potassium phenethicillin (POTASSIUM PENICILLIN-152)

Relation of ntermittent phood tevels NCILLIN utibacterial efficacy

SYNCILLIN, like all clinically available penicillins, is bactericidal. Periodic high blood concentrations may be sufficient to permit complete eradication of sensitive pathogens. According to Eagle,6 "Soon after penicillin attains effective concentrations, the bacteria cease multiplying; and the bacteriostatic effect persists for a number of hours after penicillin has fallen to concentrations that are wholly ineffective.... The therapeutic significance of this postpenicillin recovery period is enlanced by the fact that the recovering bacteria, damaged but not killed by the previous exposure to penicillin, are abnormally susceptible to the host defenses. In consequence, the bactericidal process in vivo continues for many hours after the drug itself has fallen to ineffective concentrations."

enced rate of nactivation NCILLIN by staph eniciltinuse Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms. SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers. Further, SYNCILLIN is shown to be more slowly inactivated by this enzyme than penicillin V or penicillin G. Penicillinase from B. cereus likewise inactivates SYNCILLIN less rapidly than penicillin V or G.

Indications: SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective in vitro against certain strains of staphylococci resistant to other penicillins, SYNCILLIN, like other oral penicillins, is not recommended at the present time in deepseated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage: 125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals. Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions: At the present time it is not possible to draw definite conclusions regarding the incidence of allergenicity to SYNCILLIN or its cross-allergenicity with natural penicillins. Therefore, the usual precautions for oral penicillin therapy should always be observed. Patients with histories of asthma, hav fever. urticaria, or previous reactions to penicillin should be watched with special care. Administration of oral penicillin, in rare instances, may provoke acute anaphylaxis, particularly in penicillin-sensitive individuals

Diarrhea has been reported occasionally following heavy dosage. If this occurs, lengthen the interval between dosages.

If superinfection occurs during therapy, appropriate measures should be taken. Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply: 125 and 250 mg. tablets, bottles of 25 and 100, 125 mg. powder for oral solution, 60 ml. vials.

References: 1. Wright, W. W.: Microbiology Report to Bristol Laboratories Inc. 2. Morigi, E. M. E.; Wheatley, W. B., and Albright, H.: Paper presented at the Seventh Antibiotic Symposium, November 4-6, 1959, Washington, D. C. 3. Editorial: New England J. Med. 261 3305 (Aug. 61 1959, 4. King, A.: Lanret I.:651 (March 29) 1958. 5. Epstein, E.: J.A. M.A. 169:1055 (March 7) 1959, 6. Eagle, H. and Musselman, A. D.: J. Bact, 58 3475, 1949,



When you want to reduce serum cholesterol and maintain it at a low level, is medication more realistic than dietary modifications?

Maintenance of lowered cholesterol concentration in the blood is a life-long problem. It is usually preferable, therefore, to try to obtain the desired results through simple dietary modification. This spares the patient added expense and permits him meals he will relish.

The modification is based on a diet to maintain optimum weight plus a judicious substitution of the poly-unsaturated oils for the saturated fats. One very simple part of the change is to cook the selected foods with poly-unsaturated Wesson.

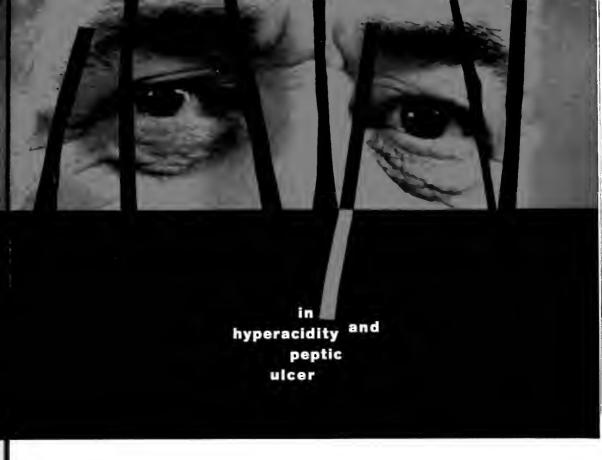
In the prescribed diet, this switch in type of fat will help to lower blood serum cholesterol and help maintain it at low levels. The use of Wesson permits a diet planned around many favorite and popular foods. Thus the patient finds it a pleasant, easy matter to adhere to the prescribed course,

Where a vegetable Isalad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpossed by any readily available brand.

Uniformity you can depend on. Wesson has a polyunsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson. No significant variations are permitted in the 22 exacting specifications required before bottling. Wesson satisfies the most exacting appetites. To be effective, a diet must be eaten by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)



beating too fast? slow it down with **SERPASIL**®



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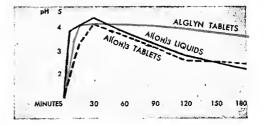


Dihydroxy aluminum aminoacetate

The superiority of Alglyn (dihydroxy aluminum aminoacetate) as an antacid over ordinary aluminum preparations is quite pronounced. Not only do Alglyn Tablets act as rapidly as aluminum hydroxide gels and magmas, but they maintain a much more effective pH for a longer time (see chart).

Furthermore, Alglyn Tablets are decidedly superior when antacid-belladonna therapy is indicated. Ordinary aluminum preparations may actually adsorb as much as 80% of the spasmolytic drug, as compared to only 7% for Alglyn Tablets. In addition, Alglyn contains no sodium and less aluminum.

Supplied in bottles of 100 0.5 Gm. tablets. Also as Belglyn® (with belladonna), and as Malglyn® (with belladonna and phenobarbital). Literature available upon request.





control the tension—treat the trauma



...Pathibamate 400

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

mebrobamate (400 mg. or 200 mg.) widely accepted tranquilizer and ... PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; lieitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: PATHIBAMATE-400 - Each tablet (yellow, 1/2-scored) contains

meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg
PATHIBAMATE-200 — Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: PATHIBAMATE-400-1 tablet three times a day at mealtime and 2 tablets at bedtlme.

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Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder

pointraindications: glaucoma; pyloric obstruction, and obstruction of the urmary bladder neck.





Lifts depression...as it calms anxiety!

For pregnant, postpartum and menopausal patients a smooth, balanced action that lifts depression as it calms anxiety...rapidly and safely

Balances the mood-no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient - they often aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation - they often deepen depression.

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety.

Acts swiftly—the patient often feels better, sleeps better, within two or three days. Unlike most other antidepressant drugs, Deprol relieves the patient quickly—often within two or three days.

Acts safely-no psychotic reactions.

Deprol does not cause hypotension, tachycardia, jitteriness, or liver toxicity. It can be safely administered with basic therapy.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d. Composition: 1 mg. 2-diethylaminoethyl henzilate hydrochloride (benactyzine HCl) and 400 mg, meprobamate. Supplied: Bottles of 50-light-pink, scored tablets. Write for literature and samples.







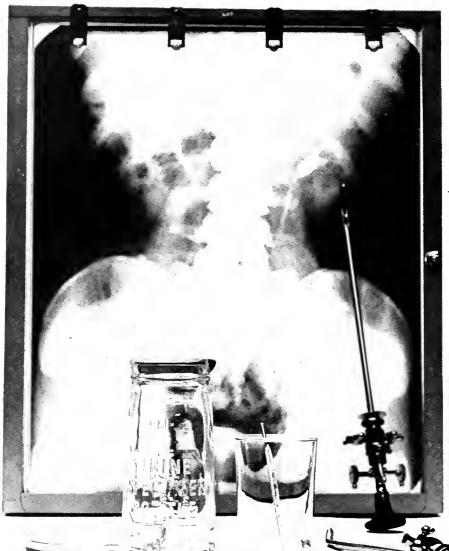
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When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

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SERPASIL-APRESOLINE hydrochloride (reserpine and hydralazine hydrochloride ciba)

C I B A summit, N. J.



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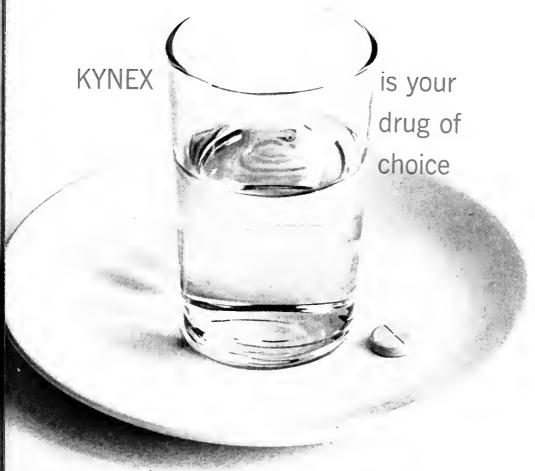
Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours^{1,2}... or approximately one-half the time of other once-a-day sulfas.² Uninterrupted control is then sustained over 24 hours with the single daily dose... through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas. Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.

Extremely low toxicity⁴... only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies⁵ in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation⁴ in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product⁶ obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antiblotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antiblotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.



nce-a-day sulfa...

E: Investigators note a tendency of some patients to interpret dosage instructions and take KYNEX on the iliar q.i.d. schedule. Since one KYNEX tablet is equivato eight to twelve tablets of other sulfas, even mode overdosage may produce side effects. Thus, the gle dose schedule must be stressed to the patient.

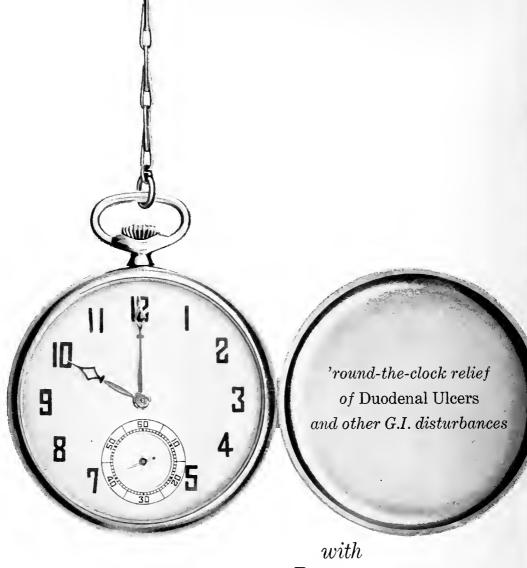
EX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Its, 0.5 Gm. (1 tablet) daily, following an initial first dose of 1 Gm. (2 tablets).

IEX Acetyl Pediatric Suspension, cherry-flavored, 250 sulfamethoxypyridazine activity per teaspoonful (5 cc.). tles of 4 and 16 fl. oz. Recommended Oosage: Children er 80 lbs.; 1 teaspoonful (250 mg.) for each 20 lb. body ght, the first day, and ½ teaspoonful per 20 lb. per day reafter. For children 80 lbs. and over: 4 teaspoonfuls Gm.) initially and 2 teaspoonfuls daily thereafter. Give nediately after a meal.

KYNEX

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX $^\$$ Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.



daricon

oxyphencyclimine HCl, 10 mg.

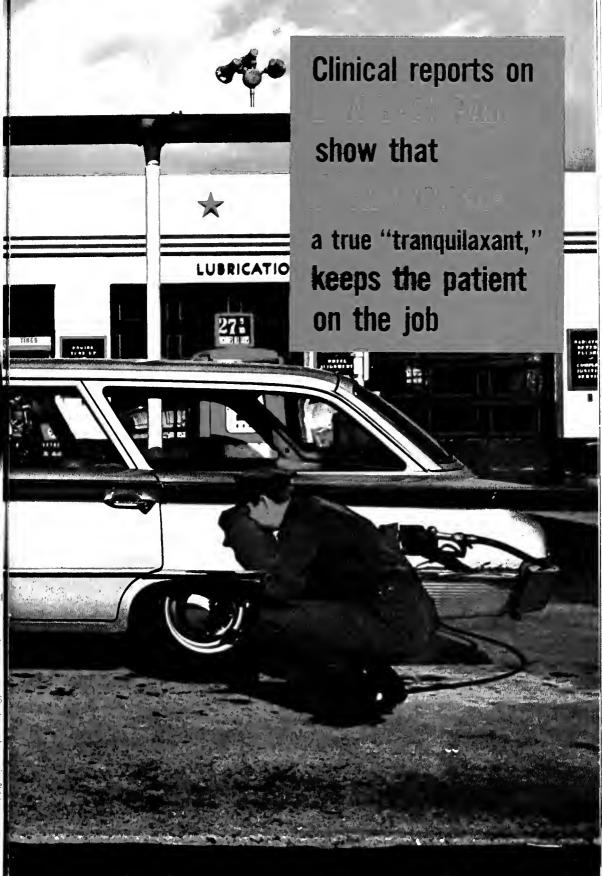
b.i.d.

"Good symptomatic responses were seen in 91 of 96 [patients] treated for periods up to one year with average doses of 10 mg. twice daily."

"[Daricon] appears to be a valuable agent...for dayto-day maintenance of all peptic ulcer patients."

Winkelstein, A.: Am. J. Gastroenterol. 32:66-70 (July) 1959.

Additional information is available on request from the Medical Department, Pfizer Laboratories, Brooklyn 6, N. Y.



A TRUE "TRANQUILAXANT" ORDANIC ORDANI



relaxes skeletal muscle spasm so the patient can continue to work

Clinical experience shows that Trancopal will enable your patients with low back pain to keep going strong. Lichtman¹ reports that 310 of his 331 patients treated with Trancopal obtained satisfactory relief. These patients were suffering from low back pain, stiff neck, postoperative muscle spasm or other skeletal muscle spasms associated with trauma, bursitis, osteoarthritis and rheumatoid arthritis. Mullin and Epifano² reported that Trancopal brought relief to all of 39 patients with skeletal muscle spasm. In these patients, who had suffered from trauma, bursitis, rheumatoid arthritis, osteoarthritis, and intervertebral disc syndrome, the effect of Trancopal was "... excellent and prompt ... "2 Gruenberg3 obtained marked relief with Trancopal in 258 of 304 patients with low back pain, torticollis, arthritis and other conditions associated with skeletal muscle spasm. Moderate relief was obtained in an additional group of 28 patients. Trancopal is a true "tranquilaxant" because "It combines the properties of tranquilization and skeletal muscle relaxation with no concomitant change in normal consciousness."4 Side effects have been few and minor — and in no case were they serious enough to warrant discontinuing the use of Trancopal.1 "Trancopal is exceptionally safe for clinical use."3

relieves anxiety and tension so the patient can carry on



Trancopal is also an effective agent for patients in anxiety and tension states. According to recent clinical reports, 1.5 it calms the patients but allows them to continue their work or other activity. Indeed, Lichtman found that his patients with anxiety "... were in many instances able to continue their normal activities where previously they had been considerably restricted ..." He observed that Trancopal brought good to excellent relief to 114 of 120 patients in anxiety states. Ganz, 5 who noted good to excellent relief in 32 of 35 patients with globus hystericus, and in his entire series of 100 patients in anxiety or tension states, comments: "Chlormethazanone [Trancopal], by relieving the psychogenic symptoms, allows the patient to use his energies in a more productive manner in overcoming his basic problems."

Relieves dysmenorrhea — Trancopal has also proved to be a useful medication in the treatment of patients with dysmenorrhea, 1,4,6 probably producing its effect "... by means of a combination of muscle relaxant and tranquilizing actions."

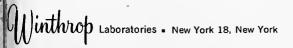
Indications

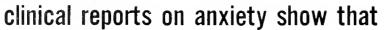
Musculoskeletal disorders		Psychogenic disorders
Low back pain (lumbago)	Ankle sprain, tennis elbow	Dysmenorrhea
Neck pain (torticollis)	Osteoarthritis	Premenstrual tension
Bursitis	Rheumatoid arthritis	Anxiety and tension states
Fibrositis	Disc syndrome	Asthma
Myositis	Postoperative muscle spasm	Angina pectoris
		Alcoholism

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms generally occurs promptly and lasts from four to six hours.

How Supplied: Trancopal Caplets® 100 mg. (peach colored, scored) and 200 mg. (green colored, scored), bottles of 100.

References: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. 2. Mullin, W. G., and Epifano, Leonard: Am. Pract. & Digest Treat. 0:1743, Oct., 1959. 3. Gruenberg, Friedrich: Current Therap. Res. 2:1, Jan., 1960. 4. Shanaphy, J. F.: Current Therap. Res. 1:59, Oct., 1959. 5. Ganz, S. E.: J. Indiana M. A. 52:1134, July, 1959. 6. Stough, A. R.: J. Oklahoma M. A. 52:575, Sept., 1959.





quiets the psyche but leaves the patient alert

"...TRANCOPAL is a most valuable drug for relieving tension, apprehension and various psychogenic states." 5



it started as a

> to prevent the sequelae of u.r.i. ... and relieve the symptom complex

Otitis, tonsillitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.1 To protect and relieve the "cold" patient... ACHROCIDIN.

Usual desage: 2 tablets or tenspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TAPLET contains: ACHROMYCIN® Tetracycline (125 mgJ; phenacetin (120 mgJ); caffeine (30 mgJ); salicylamide (150 mgJ); chlorothen citrate (25 mgJ). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygione 71:122 (Jan.) 1933



"life saving" in many cases...



INJECTION EAST REAL RESIDENCE TO SUIfate injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections ...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many in tance at effect has been dramate and life scare."

"Six of the patient who unvived were considered to be term or " all at the time kanamycin was started but showed deamate improvement and eventual compacte regovery."

"...indeed, the result of with liminancing are the continuously hable even as lieved with otherwise fatal stands logocial intection, that we have easily each "

There appears to be co-doubt that har ansem has been be a fine n to so the tance in which organishad restricted possible. There exists an anti-sectional \mathbb{C}^n

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SUPPLY description of the control of

RITHONOS I

BRISTOL LABORATORIES, SYRACUSE, NEW YORK



THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX

Special Advantages

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unusually safe; tasty syrup, 10 mg. tablet

> ELDERLY PATIENTS

well tolerated by debilitated patients



useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria



does not impair mental acuity

Supportive Clinical Observation

"... Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior..." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.

"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.

"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life...ln chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.

"... especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957.

> New York 17, N.Y. Division, Chas. Pfizer & Co., Inc. Science for the World's Well-Being

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries. Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.

adverse clinical reaction ever documented.

Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.

Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

...and for additional evidence

Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.

Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics 11:312 (July) 1956.

Eisenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.

Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. 169:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.





FOR

SEVERE PAIN

A. P.C. WITH DEMEROL (30 mg.)

1 or 2 tablets three or four times daily.

Considerably more effective than A.P.C. with codeine.

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Certified—before introduction—by 5 years of clinical experience and published reports in the U.S.A., Canada and Great Britain.

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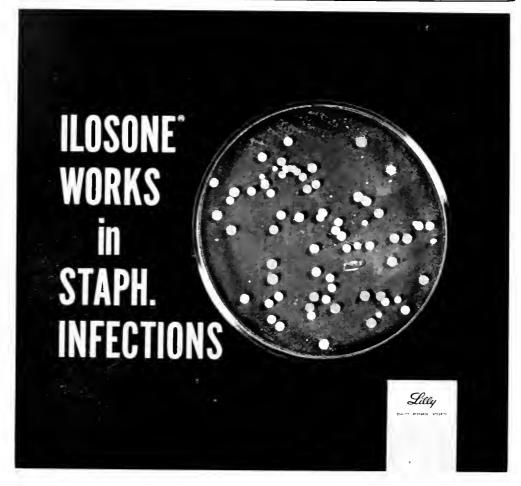
control at every stage of anticoagulant therapy rapidity of induction and recovery time predictability of initial and maintenance dosages Stability of therapeutic prothrombin levels during maintenance therapy reversibility of anticoagulant effect with vitamin K_1 preparations...rapid return to therapeutic levels on remedication

Well tolerated and relatively nontoxic no nausea and vomiting, proteinuria, agranulocytosis or leukopenia yet observed—chromaturia infrequent and transient.

Single daily dose convenience

Packaging—Miration Tablets 50 mg., bottle of 100.

For complete information on indications, desage, precautions, and contraindications consult the Schering Statement of Directions.



"In our hands it has been particularly helpful in the treatment of staphylococcic disease."

In difficult staph, infections, a decisive response may be obtained with Ilosone in a high percentage of cases.

In a study of 105 patients, sixty-four of whom had Staphylococcus aureus infections, good results were obtained with Ilosone in 94 percent. Ten subjects had previously failed to respond to other forms of chemotherapy. The authors concluded that Ilosone ". . . is useful in treatment of a number of common infections and has been effective in treatment of a number of less common and more serious infections. . . . In our hands it has been particularly helpful in the treatment of staphylococcic disease.'

Ilosone is available in **Pulvules**, 125 mg. and 250 mg.: Lauryl Sulfate **125 Suspension**, 125 mg. base equiv. per 5-cc. tsp.; and Lauryl Sulfate Drops, 5 mg. (base equiv.) per drop. Usual dosage for adults and children over fifty pounds is 250 mg. (propionyl erythromycin every six hours.

1. Smith, I. M., and Soderstrom, W. H.: J. A. M. A., 170.184 (May 9), 1959.

ester Lilly)

NORTH CAROLINA MEDICAL JOURNAL

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No. 4

Brighter Financial Prospects For Senior Citizens

G. WARFIELD HOBBS. III*

NEW YORK

illness

Merely because I am a Wall Street Banker many people might think I am violently opposed to the Forand Bill, which is aimed at providing medical services for elderly people under government jurisdiction. On the other hand, those who know me as chairman of the National Committee on the Aging are inclined to believe I am in favor of the Forand Bill.

Neither assumption is entirely correct. As an orthodox and somewhat conservative economist, I instinctively shy away from most intrusions of government into the everyday working lives of people.

I am not so backward nor naive, however, that I fail to realize that as we become more densely populated, more industrialized, and consequently more interdependent, the government must necessarily establish more and more ground rules for playing the game of life.

- 1. Superb medical care and knowledge is available from our very superior medical profession.
- 2. Elderly people need more medical care on the average than do younger people.
- 3. Elderly people on the average are less able than younger people to pay for medical care.
- 4. To date the federal government has imposed few restrictions or compulsory ground rules upon the medical profession. There is still plenty of opportunity to resolve whatever problems exist within the framework of private enterprise.

establish more and more ground rules for playing the game of life.

No part of this game is more vital than that of health. My observations as a socioeconomist reveal four major points in the health area:

1. Superb medical care and knowledge is

here today are very simple. I would like to add to the very fine medical discussions you will hear at this conference a few points concerning: (1) why so many of our present aged are limited financially; (2) why the elderly of future generations will be better off financially and thus better able to meet medical costs from private

The Present Plight of the Aged

means; and (3) one or two suggestions for

meeting the medical requirements of our

The word "problem" is here used delib-

erately, because there is a problem, and we

must face it. I am speaking of our problem,

the provision of adequate medical care for a large and increasing part of our popula-

tion-namely, the aged. I am speaking of

their problem, the dreaded possibility of

becoming the indigent aged - charity

patients—through having lifetime savings swept away in the catastrophe of prolonged

It is not my purpose to dwell upon this social enigma. We all know it exists and

that a solution must be found. I can best point it up by making the flat statement

that no one in this room would become a

having found the solution. My objectives

Nor is it my intention to lay claim to

charity patient—willingly.

senior citizens.

All around us is abundant evidence that for the fortunate the later years can be pleasant and rewarding. By contrast, the living conditions of the indigent aging are all the more shocking. They subsist in an atmosphere of loneliness, rejection, and poverty, aimlessly waiting, even hoping, for the last tick of the clock.

The Federal Security Administration reports that for the country as a whole,

framework of private enterprise.

*Chairman of the National Committee on the Aging and

Vice President of the First National City Bank of New York.

2,408,000 individuals over 65 years of age received Old Age Assistance in August of 1959. This means that about one in every six of the 15,400,000 people over 65 had no financial resources, or so little that they were forced to become dependent upon what amounts to tax-supported charity. Furthermore, countless other oldsters are kept from the public charity rolls by family and friends. This includes many of the great numbers who live in the spare rooms or attics of the three- or even four-generation homes, often to the detriment and forced resignation of all the generations.

One out of six is the official record. Two out of three probably is closer to the actual record, as indicated by numerous surveys. This seems a discouraging percentage of our elderly who require complete or substantial financial aid in this the richest country in the world. It is a poor reward for a long and often useful and hard-working life.

Public and private resources

In order to care for these unfortunates, the federal government has entered into an Old Age Assistance agreement with each of the 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

Perhaps oversimplified, and certainly with some variations, this program amounts to federal matching of state and community old age funds up to a maximum average of \$65 per month per person. If a state assistance program exceeds \$65 per month, the excess cost is borne by the state and community without federal assistance.

Old Age Assistance is doled out according to a means test of need. Consequently it is quite possible for one person to receive much more than another somewhat less needy. The monthly average to all recipients, however, must not exceed \$65, or the excess must be paid locally.

There is not much excess according to the April, 1959, figures on Old Age Assistance released by the Department of Health, Education, and Welfare. The national monthly average was \$64.49, of which about \$8.50 consisted of free medical services rendered to the individual, but paid for by the program. Although 26 states exceeded the \$65 average, only 13 exceeded \$75. The five states with the highest pay-

ments were Connecticut, \$110.10; New York, \$100.95; Massachusettes, \$99.98; Colorado, \$97.14; and Washington, \$88.61. The two retirement states of California and Florida were \$84.03 and \$53.64 respectively. The five states with the lowest rates were Mississippi, \$29.14; West Virginia, \$34.24; South Carolina, \$38.01; North Dakota, \$39.20; and Virginia, \$40.79.

Of our 15,400,000 oldsters, 2,431,000 are receiving federal, state and local assistance, averaging \$64.49 per month, or about \$775.00 per year. Whereas many of these have no other source of income, some 600,000 also receive a very small pension from Old Age, Survivors and Disability Insurance. Likewise some own homes, but have so little cash income that they must be aided.

To illustrate the inadequacy of these amounts, various welfare agencies have estimated that approximately \$2,300 to \$2,400 per annum is the bare minimum requirement for an elderly couple living in an urban area. A single individual might scrape by on \$1,500. Such a budget assumes that major medical expenses will be provided through tax-supported or charitable agencies. It virtually ignores recreation, books, movies, or any kind of social life. It permits only a bare, drab, minimal existence. Yet, one sixth of our older citizens are on the public assistance rolls and do not receive even this minimal amount.

At least three times as many more, although not on the public rolls, are living on a similar substandard basis, as shown by the 1958 Federal Reserve survey of the cash resources of the elderly. Many are supported in whole or in part, not by public relief but by relatives, friends, fraternal orders, unions and religious groups. Although estimates vary, it is unhappily clear that close to four out of five old people are seriously lacking in financial resources. Conversely, only one in five is reasonably well off, and only a small portion of this fortunate 20 per cent are fairly affluent.

Latest reports from the Commerce Department and the Federal Reserve Board indicate that of all persons aged 65 or older, about three-fifths had cash incomes of less than \$1,000 in 1958. Another one-fifth had incomes ranging between \$1,000 and \$2,000. The remaining fifth, or about

3.000.000 oldsters, had incomes exceeding \$2,000, but only 750,000 of these exceeded \$5,000. This impecunious picture is brightened slightly by the fact that cash income does not include the value of homes owned nor of food raised by farm dwellers. Fortunately more than 65 per cent of the urban elderly own homes or are married to a home owner. Less than 25 per cent live in rented dwellings. More light is shed on the income status by the June, 1959, announcement of HEW that in December, 1958, only one third of the men and one twelfth of the women over 65 were gainfully employed. Hence, of the 7,000,000 men over 65, about 2,310,000 are working as compared with the 700,000 of 8,400,000 women over 65 who work. About 25 per cent of the men are widowers, but more than 50 per cent of the women are widows.

It is further indicated that about 80 per cent of those employed are under the age of 75. We know that the 3,000,000 aged reported to have incomes over \$2,000 in 1958 must include most of those in the employed group, who therefore are under the age of 75. The inescapable conclusion is that of the more than 5,000,000 persons over age 75, although quite a number own homes, only a small per cent have any personal or private cash income at all. It seems clear that of the present generation of oldsters, the higher the age, the less likelihood of sufficient financial resources.

This supposition is substantiated by Old Age Assistance reports showing that of those aged 65 to 69, only one in ten receives aid, whereas of 2,000,000 over age 80, one in three receives public aid.

Factors Contributing to the Age— Poverty Ratio

One explanation of the age-poverty ratio is, of course, that the very old, merely by living longer, have used up their resources. That is only part of the answer. A more comprehensive explanation involves a brief analysis of the characteristics of the aged. It also requires looking back into the economic patterns influencing their productive years from youth onward.

The backward look brings to light two factors. First, it helps explain the low financial status of our very old; and, second, it most encouragingly indicates that this sorry state will end within a few years and

will not be repeated with forthcoming generations of senior citizens.

When it is considered that the median age in the United States is 29.8 and that there are 135,000,000 people under the age of 50, it is easy to understand how difficult it is for us as a nation to have even the vaguest idea of the economic climate and working conditions back in the eighties and nineties, when our very old began their adult lives.

Education and earning power

Education is a direct coefficient of earning capacity. Before the turn of the century the 9,000,000 who are now over 70 were leaving school, on the average, in the sixth to eighth grades. There were no child labor laws. There were few compulsory school laws. These people were entering a predatory labor market ill equipped to earn a comfortable living. Numerous studies by the Census Bureau show that the high school graduate earns more than twice as much as those who merely attend grammar school. College graduates continue to prove the advantage of education by earning twice as much as high school graduates. An automated and service-oriented world will place an even greater premium upon education.

In 1900 only 72 per cent of the children between the ages of 5 and 17 were even enrolled in grammar school or high school. Twenty-eight per cent were not in any school: they had dropped out and were working or, if they were girls, probably helping at home. At that, the 72 per cent who attended school managed to be present on an average of only 99 days out of the entire school year. In 1954 the Census Bureau reported that 89 per cent of the 5 to 17 year age group attended school on an average of 159 school days. The educational exposure of our present total youth group is therefore about double that of 1900. The continuation and completion of higher education is even more impressive. In 1900 only 94,800 graduated from high school and only 27,410 graduated from college. In 1957, 1,358,000, or 14 times the number in 1900, graduated from high school, and 340,000 (12 times the 1900 figure) graduated from college. Allowing for the fact that our population has somewhat more than doubled since 1900, the proportion of graduates is at least six times what it was at the turn of the century.

Immigration

Although less than 7 per cent of our total population is foreign born, of those over 65 about 24 per cent are foreign born. This reflects the fact that between 1870 and 1930 more than 30,000,000 immigrants of all ages sought a home in America, but since 1931 only 3,000,000 have come to this land of opportunity.

All of us, except Will Rogers and his kinfolk, are descended from immigrants. The very number of these immigrants created a glut in the labor market that kept wages at depressed levels. Of course their journey to the new country was worth while. They all achieved the priceless heritage of personal freedom and equal opportunity. Nonetheless they did not find our streets paved with gold. They found a rural country changing into the world's greatest industrial complex. Jobs were available, but the vast majority of immigrants found that the language barrier and lack of education kept them from rising to well paid employment. For their children and grandchildren the horizon was limitless, but for them. despite the glamorous success stories, there were only a few Pulitzers and Steinmetzes. Consequently, a high percentage of the survivors of these modern Argonauts are presently dependent upon Old Age Assistance.

Rural society

In 1880 nearly three-fourths of our population was rural. As late as 1910 more than 54 per cent of our 92,000,000 population were classified as rural. Some 35 per cent lived on farms and another 19 per cent lived in villages and towns of under 2,500. By 1956 only 13 per cent of our population were living on farms and about 24 per cent in towns of less than 2,500. The sharp drop in farm population is the significant figure, since the increase in small towns reflects the fantastic migration to surburbia and exurbia that developed after World War II.

In a predominately rural country such as ours had been, there was no insoluble problem for the aging. They simply continued to live on their farms and were cared for by children and grandchildren, as is the present case in many agrarian countries around the world. The massive trend toward industrial, retail, and service jobs changed this picture. When an older person could no longer work, he and his dependents had to fall back upon personal resources, family support, or public charity. Since the accumulation of private means was difficult, a larger and larger group of older people became dependent upon resources other than their own. This group was further augmented by medical miracles which have added 22 years to average life expectancy during the last 60 years. This, incidentally, happens to be a greater scientific advance than that recorded for the previous 2,000 years.

Low wages and unemployment

The difficulty of accumulating private resources adequate for old age is best measured perhaps by taking a look at contemporary wage rates. If you are somewhere around the median United States age of just under 30, it is hard to believe, but true, that in 1900 the average earnings of industrial workers was 1614 cents an hour, and the take-home pay for a long week was \$8.78. Because the cost of living index of 1900 was only 33.5 as opposed to a high of 125 in October, 1959, the worker of that day had a true purchasing power of about three and one-fourth times what those same wages would buy today. Nevertheless, today's equivalent of \$31 per week would not offer much chance to provide for old

To appreciate the economic hazards that confront our present 70 and over age group, bear in mind that nearly all of them entered the labor force somewhat before 1900 or shortly thereafter. Likewise our elderly widows were married to men working during this era.

By 1929 wages had risen to 56 cents per hour, but the depression of the 1930's knocked them down and a new high was not reached until the 62 cents per hour of 1937. Another disastrous effect of the depression was widespread unemployment. We were quite properly concerned when, at the depth of the 1958 recession, it was reported that 1 in each $13\frac{1}{2}$ in the labor force was out of work. In 1932 almost 1 in 4 was out of work. By 1937 the depressing figures were still 1 in 7 unemployed.

For various reasons, mostly unjustified, there is a prejudice against hiring men and women over 40. By the end of the depression of the 1930's all of our 70 and older age group had reached their forties, fifties and sixties. Many of them severed from jobs were never able to regain steady employment except during the labor shortages of World War II. Consequently, their average lifetime earning upon which their Social Security pension is based remained low despite a continual rise in wages.

The cumulative effect of these restrictive economic forces upon our present crop of oldsters shows why it is not for lack of individual effort that only 1 in 5 has an income in excess of \$2,000, and more than 2,408,000 are on public relief rolls. Despite numerous stories of amassed wealth, the truth is that the Horatio Algers could form only a very small and exclusive club.

Grounds for Hope

For those who today are between 45 and 65, the outlook is brighter. In 20 years, when they reach 65 to 85, those dependent Old Age Assistance will have been reduced to an insignificant proportion. A great majority will be self-respecting and financially independent as the result of a combination of Federal Social Security pensions, private pensions, private savings, and wider home ownership.

That this favorable forecast is not a wild dream is shown by the following factors. Twenty years ago, in the early days of Social Security, less than one third of the workers were covered. Today more than 9 out of 10 are eligible to receive Old Age Survivors and Disability Insurance. Now included are the self-employed, farmers, nonprofit employees, and state and municipal employees. As recently as October, 1948, the average monthly primary benefit allotted was only \$25.28. In July, 1959, it was \$81.44, and steadily rising. After 1958 the maximum primary benefit could range between \$118 to \$127 per month. Since 1954 the number of primary beneficiaries, exclusive of dependents, has more than doubled, so that today more than 7,000,000 (45 per cent) of our old people are receiving federal pensions towards which they paid taxes.

Private pensions and deferred profitsharing plans are fast becoming an important economic reserve for the elderly.

In 1940 there were less than 1,000 plans, covering about 3 million people. In 1950 12,000 plans covered about 9,000,000 active workers and less than 400,000 retired workers were receiving private pension checks. At the end of 1958 more than 47,000 plans covered 18,000,000 active employees, and about 1,250,000 retired employees were receiving pensions averaging about \$1,000 per year. Private pension benefits and coverage are rising rapidly. In 1958 alone there were 6,954 new plans, covering a million workers. The original industrial formula of \$100 a month less Social Security has become \$2.50 per month for each year of service in addition to Social Security. Many salary plans are basing pension benefits upon final pay instead of the much lower average lifetime earnings. There is no doubt that within a generation or less most of the labor force will be protected by private plans supplemental to Social Security.

Other favorable indices are increasing home ownership and rapidly expanding cash and marketable assets. These include all types of cash savings accounts, U. S. Government Savings Bonds, and net reserves of life insurance companies. The per capita increase in these liquid assets has been fourfold just since 1939. The inroads of inflation have cut the net gain in half, but the trend remains extremely favorable for those approaching old age.

The New York Stock Exchange reports that since the last survey in 1956 the number of individual shareholders has increased from 8 million to 12½ million. Of these, 38 per cent are over the age of 55.

Perhaps the most dramatic, and certainly the most far-reaching, factor has been the increase in wages. From a lowly 161/2 cents per hour the gross rate rose to \$1.40 in 1949 and in May, 1959 reached \$2.23. This is a gain of 13 to 1 over the entire period and up to 60 per cent in the last 10 years. Inflation and greatly increased taxation however, have taken their toll. The Bureau of Labor Statistics shows that true purchasing power, or "real wage" adjusted for inflation and after taxes, rose from an average weekly rate in 1900 of \$26.21 to \$65.35 in May of 1959. Thus the average worker today is two and one-half times better off than his counterpart of 1900. In just the last 10 years his net gain has been

24 per cent. So at long last we are achieving the dreams of our forefathers. Our system of individual freedom and private enterprise is now producing an adequate income and standard of living for all but a small minority. We have reached a plateau in our economic progress where more people have more. We are on the verge of becoming in reality an affluent society.

As proof that the new generation of older citizens is attaining greater financial independence, current Old Age Assistance figures may be cited. In 1950 the number over age 65 receiving public assistance reached a high of 2,789,000. In August of 1959 there was a decrease to 2,408,000 despite the fact that there were 3,000,000 more in the aged group. The reduction continues at the rate of about 3,000 per month in spite of a net gain in the number of aged of about 30,000 per month. During 1959 about 900,000 of the over-65 group will die, but the group will increase because close to 1,250,000 will become 65 this year.

Unhappily, many of our great gains came too late to benefit a large segment of our very old. In seeking a solution, we must not forget that it was during their working lives, spanning three-quarters of a century, that we learned many of the lessons that have produced today's highly successful economy.

Summary and Conclusions

I have tried to document the point that today we have a very large group of several million aged with so little resources that they must be assisted financially, not only as regards health care, but in all living conditions. I have tried to demonstrate that this unfortunate group is diminishing both numerically and proportionately. They are being replaced by newly aged, who are increasingly able to care for themselves.

Consequently, I wish to emphasize that a long-range health program should not be predicated upon the assumption that to-day's proportion of extreme hardship cases will prevail indefinitely. There is no doubt that some government help is now required, but it is highly questionable that such extensive medical assistance will be necessary for our aged 10 to 20 years from now.

I make this bold prediction because I am firmly convinced that two present trends will become future facts.

- 1. The average standard of living of the next generation will be immeasurably higher than at present.
- 2. The American medical profession in conjunction with insurance companies, business and labor leaders will attack vigorously the health care problem and find a solution under the principles of free enterprise for the vast majority, leaving only the diminishing number of indigent under the protective wing of government.

To evolve a practical and financially feasible plan for our aged to meet the rising cost of medical care, I propose consideration of the following suggestions:

- 1. Continue to expand private pensions until all employees are covered, in contrast to only 25 per cent at present.
- 2. Amend all private pension plans so as to provide portability, or vesting of benefits when jobs are changed, exactly as with the Teachers Insurance Annuity Association.
- 3. Permit retired employees to continue membership in all company Blue Cross, Blue Shield, major medical and other health plans at the same dollar premium paid by active employees and with no reduction or limitation on permitted benefits other than those in the active employee plans. This means younger employees will pay slightly more than their actuarial share, as is the case with group life insurance plans. They will recapture the overpayment when they too enter the older ages.
- 4 Insurance companies should sharpen their pencils and come up with imaginative comprehensive individual and group medical policies. These policies should be based on the principle of level premiums according to age at entry, exactly as with ordinary life and annuity policies. These policies could be arranged to commence deferred payments at any age over 65. The medical benefit payments could be calculated to average a specific amount over life expectancy after age 65, and to be paid not in specific amounts each year like a regular annuity, but only as required for medical services with the total payments not to exceed a cumulative total actuarially computed for each age after 65. This sounds complicated, but it really is not, and every insurance actuary I know admits better policies than now exist could be created.

5. Finally, I recommend that all of the doctors in the country study the Palo Alto, California Medical Plan for those over 65. Here, Dr. Russell Lee and several of his medical cohorts have agreed to care for about 1,000 people over 65 for an annual payment of \$100 each. I do not know the details, but I know it is working, and is a splendid demonstration of how private enterprise can hold its own in any field.

In conclusion, let me repeat: We face a serious problem in meeting the advancing medical cost of our over 65 population, in spite of their improving economic status. There is also no doubt that a solution will

be found. The only question is, will the solution be good or bad?

The Forand Bill is a specific answer. You cannot beat something with nothing. Therefore, my medical friends, my advice is to stop moaning and groaning about the Forand Bill. Instead, get together with the Blue Cross, Blue Shield, HIP, insurance companies, industry, management, and labor and devise a cooperative plan that will be an improvement over the Forand Bill, and, under private enterprise, give your older population the medical care they want and deserve.

Wringer Injuries

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"Wringer injury" is a term applied by MacCollum(1), in 1938, to damages incurred when the upper extremity is caught between two rollers. Since the advent of the automatic washing machine and the perfection of the release mechanism, the incidence of these injuries has decreased. Far too many cases still occur, however, and their potential severity is not generally known. The injury is much more frequent in children⁽²⁾. It usually causes damage to the skin and subcutaneous tissues, but at times muscles and tendons are avulsed, with open or closed wounds. Less frequently, damage to bones, joints, and nerves has been reported. Occasional cases of avulsion of the thumb or finger have been seen.

Pathology

The distance between the rollers and the tension on them usually allow the hand and lower forearm to pass through before actual damage begins to occur. This is particularly true in children. In the small child the entire arm may pass through the rollers with very little damage until the axillary region has been reached. The compressive force and friction produced by the rollers cause damage primarily to the skin and soft tissues. The severity of damage depends upon the length of time the arm remains caught between the rollers, the rate of revolution,

and the approximation and tension of the rollers. Because of the smallness of the parts, the elasticity of the skin, and the flexibility of the bones, joints and ligaments, the prognosis is much better in the younger age groups (2). In virtually all the cases, the hand enters the roller first, with the fingers in the extended position. At the point where the arm can no longer move, friction produced by the roller action causes the damage to the skin and underlying tissues. Bones are rarely damaged, but muscles, tendons and nerves may be crushed, torn or avulsed even without a break in the skin. Sometimes, skin flaps are torn, exposing the underlying tissues. The most common damage is separation of the skin from its subcutaneous attachments by the mechanical action of the moving rollers (3). A collection of blood and serum beneath a fullthickness skin area delays the re-establishment of a good blood supply(3). Venous thrombosis and lymphatic obstruction occur frequently. The arteries in the affected zone, being less easily injured than the veins, continue to circulate blood into the damaged area, causing engorgement and subsequently necrosis. If this condition is not treated, the overlying skin, which may at first seem undamaged other than being swollen, sloughs. Occasionally, flaps of skin are completely separated, exposing contused or macerated muscle. Sometimes tendon ends are completely stripped from

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their muscle attachments, even without an open wound.

Clinical Examination

All too frequently, the physician who first sees a wringer injury does not recognize its seriousness and fails to institute the proper treatment. Most of these patients, particularly the children, are brought to the emergency room or the doctor's office because of the pain and swelling. The parents usually fear that the child has broken "something." Although roentgenograms should always be taken of the parts involved, they rarely show true joint or bone damage(4) Nerve and tendon function distal to the site of the injury should be determined immediately. In cases seen immediately after injury, the degree swelling and ecchymosis may be mild or moderate, misleading the physician who is inexperienced in treating these conditions. Occasionally, the damage may be limited to a superficial abrasion, associated with contusion and edema. In many instances, however, extravasation of blood and serum separate a flap of skin from the forearm or arm, causing severe sloughing later. The extent of the damage cannot always be determined early, and therefore the prognosis should be guarded. Sometimes the case is seen before significant leakage of serum or blood into the subcutaneous tissue has occurred. The arm may appear swollen, the patient is able to extend and flex the fingers and wrist, and there is no nerve damage. Only superficial abrasion may be evident, but one should treat these injuries in the light of their potential seriousness rather than their present appearance.

Treatment

The treatment of wringer injuries should be classified according to pathology and lapse of time since injury. I shall divide this discussion into four parts: (1) early closed injuries; (2) open wounds with skin and subcutaneous damage, (3) cases seen after sloughing has occurred, and (4) cases involving the skin and underlying muscle, tendon and nerve structures.

Early closed injuries

Regardless of the initial appearance of the injury, the patient should be hospitalized and observed for at least 48 hours. The entire area should be cleansed with pHiso-

Hex and water as though in preparation for surgery, even though the skin is unbroken. A sterile pressure dressing is then applied to the entire area and the arm is elevated. The dressing should be removed every 12 hours in order to inspect the injured area. If there is evidence of extravasation of blood and serum immediately at the point where the skin has been lifted away from the underlying tissues, small stab wounds should be made for drainage, as in skin grafting. If the skin has been lifted by underlying serum or blood in spite of pressure dressings at the end of 12 to 24 hours, stab wounds should be made to allow drainage. If at the end of 48 hours there has been no elevation of skin but only bruising and abrasion, the patient can begin to use the hand and arm, and dressings can be discontinued; however, if incisions have been made and at the end of 48 hours the part appears viable, dressings should be left on until all wounds have completely healed and the part treated as one would for an early skin graft.

Open wounds with skin and subcutaneous damage

In instances where there has been an avulsion of a section of skin particularly over the forearm or arm, if the skin is intact the fat can be completely removed and the thin skin flap sutured back in place. Occasionally, this measure will be effective and no further treatment is necessary. Rotation or sliding flaps are not successful because of the tissue damage and circulatory impairment of the surrounding tissues; therefore, if there is an open wound, particularly if bone or joint or nerve is exposed, a pedicle graft is imperative if the wound is seen immediately. The best source for such a graft is the thoracicoabdominal area. These flaps are developed from a superior base and should be one-third larger than the defect to allow for shrinkage. The length should not exceed width of the base by more than two times. The flap is carried to the external oblique tascia and transferred without any removal of fat. The abdominal defect may be closed by undermining, or, if it is too large, coverage may be completed with a splitthickness graft. The graft is dressed with moderate pressure and immobilized to relieve any motion or tension on the base. Detachment and revision are carried out in approximately three weeks. If repairs or grafts of tendons are necessary, all joints should be thoroughly mobilized passively prior to surgery. The skin should be well healed, with subsidence of induration, before definitive work is attempted in order to prevent summation of scarring.

Cases seen after sloughing has occurred

When the patient presents an open, infected wound several days or weeks after the initial injury, he should be admitted to the hospital. Wet dressings are applied and the arm is elevated. The wound should be debrided and the part prepared as soon as possible for the application of a splitthickness skin graft. All necrotic tissue should be removed at an early date and the area prepared for grafting within three days to one week. A split-thickness skin graft is then applied. After two or three months the patient is readmitted to the hospital and the contracting skin graft and underlying scar tissue are excised. A free full-thickness graft taken from a hairless area of the body is best⁽⁵⁾. (The upper thigh or groin is preferable to the abdomen or back.) The graft is taken with a very sharp knife conforming to the pattern of the area to be covered. Only the skin is removed, with no subcutaneous fat. The graft is sutured in place with very fine no. 4 to 5-0 interrupted silk sutures and a pressure dressing applied. It is imperative that the extremity be kept completely immobilized, since any motion between the graft and the underlying tissues will prevent the graft from "taking." In the cases of a hand, it is well to have a splint made, preferably of aluminum that can be sterilized, so that the hand can be immobilized by suturing the nail to the splint with fine stainless steel wire. This is particularly valuable in the young child. In cases where the dorsal aspect of the hand is involved, a split-thickness skin graft, preferably three-quarters, may be used permanently, rather than a full-thickness graft. A full-thickness graft is always necessary in the palm.

Injuries involving the skin and underlying structures

In some instances the muscles are stripped from the tendons, usually at the musculotendinous junctions, even though the skin is left intact. This type of damage is more frequently seen in the extensor than in the flexor apparatus. In such cases, the skin should be treated as described previously but the part so splinted as to avoid tension on the part that has been stripped. I recently saw a man whose arm had been caught between rollers in a mill, stripping the common extensor tendons to the middle, ring and little fingers so that he was unable to extend these fingers at the metacarpophalangeal joints. He was treated in the manner previously described, but the hand and fingers were splinted in full extension during the treatment with the pressure dressings. Fortunately, there was no subsequent sloughing, and the hand was left splinted in extension for approximately three weeks. It was felt that an operation might be necessary later, but, as is frequently the case in extensor tendon injuries, the part healed. After mobilization he had no difficulty at all in extending his fingers. An injury in the flexor aparatus would not have quite as happy an outcome, I believe, but it should be treated in like manner. If the musculotendinous junction does not heal satisfactorily, definitive surgery can be performed after all skin has healed. Prior to repairing any tendon or bone, there should be complete covering of the part by a good pedicle flap. It is useless to perform tendon grafts or sutures underneath a split-thickness graft, as the entire area will either slough off or scar down,

In some instances, the damage to the musculotendinous apparatus is so severe that reconstructive procedures are necessary to salvage function.

Case Report

An 18 year old male was seen whose forearm and arm had been caught between rollers while he was working in a mill. In this instance, the sleeve of the shirt was caught, dragging the arm into the rollers, elbow first, with complete laceration and maceration of the skin of the upper forearm and elbow. There was considerable destruction of the muscles both of the flexor and extensor surface in the region of the elbow, fortunately with no damage to the radial, ulnar, or median nerves.

This man was seen early by another surgeon who treated the wounds and performed the skin grafts in the region of the elbow and upper forearm with satisfactory results. Unfortunately, the hand had not been properly splinted during this period, and rather marked flexion contracture of the wrist and of his fingers had developed. When

seen approximately three months after the original injury, the wounds were all well healed. There was a flexion contracture of some 30 degrees of the wrist. He had further flexion passively, but no further extension passively or actively. The fingers were flexed into the palm, and no active extension could be performed except in the interphalangeal joints through intrinsic function. Fortunately, there was no damage to the extensors or to the flexors of the thumb. The wrist was mobilized as well as possible first by the use of a cast, gradually wedging the wrist up into dorsiflexion to an angle of about 20 degrees. Because of the stretch on the contracted flexors of the fingers, however, the fingers were pulled more tightly into the palm. After removal of the cast, a dorsiflexion splint was utilized along with physical therapy, getting as much passive motion in the wrist as possible. A maximum range of passive motion in the fingers was attained before any surgical procedure was attempted. On testing the muscle function after freeing some of the contracture, it was found that this man had good function in his flexor carpi ulnaris, flexor radialis, and palmaris longus. The extensor carpi radialis longus seemed to be functioning weakly. The first procedure was to excise the sublimis tendons, thus releasing much of the flexion tightness. The profundi were released and the sublimi excised completely. The flexor carpi ulnaris was transplanted into the profundus tendons. Later, the flexor carpi radialis was transplanted into the short wrist extensor, and an extensor tenodesis of the fingers was performed. transplanting the common extensors into the radius. This gave the patient a rather good functioning hand. He could pick up small objects with good pinch mechanism, and he could grasp objects but had a poor grasp for small ones.

Summary and Conclusions

The potential severity of wringer injuries should be known by all doctors treating traumatic cases. Many of these injuries

are superficial, but it is frequently impossible to tell the severity of the lesion by early examination. Every case should be treated in the hospital for at least 48 hours. Recent open wounds should be covered by immediate pedicle flap grafts. In the presence of sloughing, the area should be debrided and cleaned up as soon as possible, then covered by split-thickness grafts. These should be replaced by full-thickness grafts in approximately two to three months. Tendon and muscle injuries should be treated conservatively at first, but definitive procedures can be performed when all wounds are completely closed, when there is no evidence of induration, and when scarred areas have been replaced by good skin and subcutaneous tissues. In instances of marked damage to the musculotendinous and nerve structures, salvage procedures are necessary. The part should be well evaluated, and when reconstructive procedures are performed, the remaining viable parts should be utilized so as to give the hand the best balance possible for good function.

References

- MacCollum, D. W., Wringer Arm; A Report of 26 Cases, New England J. of Med. 218:549-554 (March 31) 1938.
- MacCollum, D. W., Bernhard, W. F., and Banner, R. L.: The Treatment of Wringer Arm Injuries, New England J. Med., 247:750-754 (Nov. 13) 1952.
- Hardio, C. A., and Robinson, D. W.: Coverage Problems in the Treatment of Wringer Injuries, J. Bone & Joint Surg. 36-A:292-298 (Apr. 1) 1954.
- Farmer, A. W.: Treatment of Avulsed Skin Flaps, Ann. Surg. 110:951-960 (Nov.) 1939.
- Posch, J. L. and Weller, C. N.: Mangle and Severe Wringer Injuries of the Hand in Children, J. Bone & Joint Surg. 36-A:57-63 (Jan.) 1954.
- Dupertius, S. M.: An Evaluation of Skin Grafts for Haud Coverage, J. Bone & Joint Surg. 34-A:811-819 (Oct.) 1952.

The question "Should a doctor tell?" need no longer be posed—anyhow, not in regard to telling the patient about his illness. Through instruction in health magazines, the *Reader's Digest*, and radio and television programmes, patients acquire that superficial knowledge which often emboldens them to question their doctor more closely than hitherto about their own complaints. Of course it is unlikely that a patient can have any real understanding about his illness, but the greater risk that he will obtain misguided information from less reliable sources has to be reckoned with.—Evans, W.: Faults in the Diagnosis and Management of Cardiac Pain, Brit. M.J. 1:252 (Jan. 31) 1959.

Treatment of Avulsion Wounds of the Extremities

J. S. GAUL, JR., M.D.

CHARLOTTE

The purpose of this paper is to report my experience with a type of injury that requires special attention and that perhaps has been treated incorrectly on occasion. Six references from the literature support this contention. Avulsion wounds (in which the covering skin is forcibly avulsed from the underlying portion of the body) frequently cause disabling loss of skin when treated simply by wound debridement and skin suture. These wounds are a special problem which should be recognized by the surgeon who treats fresh trauma. Recognition of the particular nature of the problem, and the institution of proper surgical treatment will reduce the resulting disability and often avoid subsequent surgical repair.

The nature of all mechanical contrivances, including industrial machinery, is such that when a limb is caught by moving parts and drawn inward, skin is often avulsed, and often with its base distal, leaving a retrograde avulsion flap. When the machinery is turning outward, the limb is not caught in the first place, but is extruded.

The problem with avulsed skin lies in the damage to the venous circulation, which is often rendered inadequate to maintain the viability of the skin covering. This is most marked when the flap has been torn loose in a retrograde direction. The initial satisfactory appearance of avulsed skin is deceptive: arterial inflow is often sufficient and venous drainage may suffice for the moment through torn veins. Torn and damaged veins, however, eventually result in clotting; the flap becomes cyanotic within a few days and sloughs within a week or two. Further repair is then necessary, and disability often results.

The solution to this problem is to trim away all subcutaneous tissue and blood vessels, leaving a thin epithethial flap similar to a free full-thickness skin graft, which "takes" like a skin graft when sutured back

into place (figs. 1, 2, and 3). The cutaneous cells themselves are very resistant to trauma.

The problem of avulsion flaps has been recognized and discussed in the literature

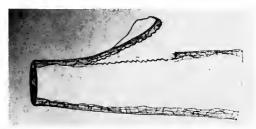


Fig. 1. Avulsed skin flap.

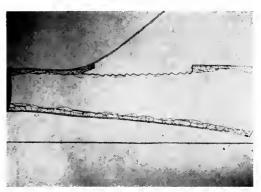


Fig. 2. Flap trimmed of all subcutaneous areolar tissue, leaving epithelium only.



Fig. 3. Epithelial flap replaced as a free, full-thickness graft, dependent upon the underlying bed, not its damaged blood supply, for nutrition.

on several occasions. Dr. A. W. Farmer, a plastic surgeon of Toronto, deserves credit for being the first to recognize the nature of this problem and to treat it by

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Fig. 4. (Case 4) Retrograde avulsed wound.

the foregoing method⁽¹⁾. Subsequent reports by Stevenson⁽²⁾, Matheson and Gerber⁽³⁾, Slack⁽⁴⁾, Mulholland and Mahoney⁽⁵⁾, and Prendiville and Lewis⁽⁶⁾ have reemphasized the nature of the problem and the need for special consideration. The aforementioned type of surgical treatment has frequently been recommended.

My experience with 6 cases of avulsed flaps is as follows:

Case 1

A middle aged baker suffered a dorsal retrograde avulsion of the skin of his left thumb by a dough-cutting machine. This injury was associated with a compound fracture of the distal phalanx. The flap appeared to maintain a good circulation when treated by me, and was sutured back in place. It became cyanotic in two days, black in six days, and was excised and replaced with a split-thickness skin graft. Permanent partial disability of the thumb resulted.

Case 2

A middle aged machinist suffered a large skin avulsion from the dorsum of his right hand in a textile mill. The flap was described by the attending surgeon as based distally on the top of the fingers in a retrograde manner, leaving the entire metacarpal phalangeal joints and proximal phalanges of all four fingers uncovered. The attending physician cleaned and sutured the skin flap back in place. It was found to be necrotic at the end of two weeks. It was excised and replaced with an abdominal skin flap, and later two extensor tendon grafts were placed in the central fingers. A usable hand resulted, but some deformity and disability remained.

Case 3

A mill supervisor suffered a large avulsion wound of the palm of his left hand. The flap, described as measuring 2 by 2 inches with a base in the distal palm, was cleaned and sutured back in place at the time of injury. It was said to be cyanotic by the third day, and grossly necrotic on the eighth. It was excised and replaced by an ab-



Fig. 5. Hand seen in figure 4, four weeks after repair.

dominal pedicle graft by the attending physician. Permanent disability in the form of joint and tendon stiffness resulted. In my opinion and that of another consultant, the stiffness and scarring were probably too widespread to make surgical correction feasible.

Case 4

A 60 year old housewife tore open the volvar aspect of the right index finger on a washing ma-



Fig. 6. (Case 5) Severe avulsed flaps from foot.



Fig. 7. (Case 5) Results eight weeks after injury.

chine, producing a retrograde skin flap measuring about 1 by 1 inch, with a base over the middle finger crease. This finger was cleaned under general anesthesia, and the avulsed skin was thinned out to form a full-thickness skin graft by excising all subcutaneous tissue. It was then sutured back into place, and the finger was splinted for 10 days. No skin was lost and almost complete range of function returned in four weeks. (See figs. 4 and 5.)

Case 5

A middle aged Negro went to sleep on the railroad track, where a train backed over his right foot literally squeezing it out of its skin except for the plantar skin which remained attached. The flaps were completely trimmed of all subcutaneous tissue down to epithelial thickness only, and replaced as full-thickness skin grafts. A small patch of skin measuring 1 by 1 inches was lost at the time of injury. When the foot was dressed two weeks later, these flaps had "taken" about 90 per cent, leaving a small area about 1 by 2 inches on the dorsum of the foot. This was covered by a secondary split-thickness skin graft. The man resumed work as a construction laborer eight weeks after the injury. (See figs. 6 and 7.)

Case 6

A young white man suffered a crushing wound of the lateral aspect of the right foot when struck by a falling steel beam. A compound fracture of the fifth metatarsal bone did not require manipulation. The wound was cleaned and the bi-pedicle skin flap converted into a full-thickness graft by cleaning and trimming away all subcutaneous tissue. It was then sewed back in place. Only about 30 per cent of this flap survived; the remainder sloughed, and the entire area was late replaced with skin graft at a second operation. The patient returned to work in about three months.

Conclusion

Wounds that avulse large areas of skin often lead to subsequent necrosis in spite of the initially satisfactory appearance of this type of skin injury. The potential nature of this problem must be understood by the surgeon treating fresh wounds. Large avulsed flaps, and particularly retrograde avulsed flaps, should be converted immediately into full-thickness epithelial skin grafts in order to survive at all. My experience with 6 cases is presented to illustrate this fact.

References

- Farmer, A. W.: Treatment of Avulsion Skin Flaps, Ann. Surg. 110:951-960 (Nov.) 1939.
- Stevenson, T. W., Jr.: Principles of Treatment of Avulsion of Skin; Surg. Clin. North America 21:555-564 (April) 1944.
- Matheson, C., and Gerber, A.: Surgical Management of Extensive Avulsions of Skin, Am. J. Surg. 74:665-676.
- Slack, C. G.: Friction Injuries Following Road Accidents, Brit. M. J. 2:262-263 (Aug. 2) 1952.
- Mulholland, J. H. and Mahoney, J. H.: Massive Avulsion of Skin, Am. J. Surg. 83:359-363 (March) 1952.
- Prendiville, J. B., and Lewis, E.: Pneumatic Tyre Torsion Avulsion Injury, Brit. J. Surg. 42:582-587 (May) 1955.

Once the diagnosis of cardiac pain has been excluded, the information should be conveyed to the patient immediately and emphatically. Reassurance is not reassuring if it is given late or without conviction, for the mental wound, unless repaired quickly, is sure to fester. A life saved from the bondage of unwarranted invalidism justifies the great care taken to avoid it.—Evans, W.: Faults in the Diagnosis and Management of Cardiac Pain, Brit. M.J. 1:251 (Jan. 31) 1959.

The Post-Myocardial Infraction Syndrome of Dressler

Case Report

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CHARLOTTE

An unusual disorder, described first by Dressler in 1955, appeared recently in an elderly man convalescing from a myocardial infarction. This syndrome simulated certain grave postmyocardial complications, including pneumonia, heart failure, pericardial hemorrhage, and uremia. Its manifestations also prompted consideration of collagen disease, endocarditis, pulmonary embolism, and aortic dissection. We are reporting this case because of the paucity of corroborative reports in the literature (2-5). Dressler himself, in his latest presentation (6), states that he has seen 53 cases of this syndrome and estimates that it complicates three to four per cent of all cases of myocardial infarction.

Case Report

A 63 year old retired salesman was noted on November 15, 1953, to have a baseline blood pressure of 220 systolic, 110 diastolic. On April 7, 1957, while gardening, he experienced substernal pain radiating to the arms and posterior nuchal region of short duration and mild intensity. In the early hours of April 8, 1957, he was awakened by intense discomfort similar to that experienced the afternoon before, accompanied by diaphoresis and notable angor animi. Serial hospital observations over the next three days indicated that the man had sustained infarction of the posterior and diaphragmatic cardiac wall. These were: (1) a rise in SGOT* levels to 385 units on the second day; (2) the development of persistent arterial hypotension; (3) the appearance of a cardiac friction rub; (4) serial electrocardiograms showing a static intraventricular conduction defect ("parietal block") together ST-T wave changes indicating posterodiaphragmatic myocardial necrosis 1); and (5) the appearance of fever, leukocytosis, and C-reactive protein in the serum. Anticoagulant therapy with phenindione ("Danilone") was initiated during the first 24 hours and continued throughout convalescence.

On the second hospital day the patient experienced mild, steady anterior chest pain and tachypnea. A grade IV pericardial friction rub was heard along the left sternal border; bilateral crepitant basal lung rales, and a faint apical third heart sound thought to be a diastolic ventricular gallop were present. Oral temperature measured 101 F. The nonprotein nitrogen was 35 mg. per 100 cc., and the prothrombin time was 25 per cent (19.5 seconds). A portable chest x-ray showed basal pneumonitis bilaterally and minimal cardiac enlargement. A daily injection of 0.5 Gm. of streptomycin and 300,000 units of penicillin ("Combiotic") was begun on the second day and full digitalization was accomplished over the next three days along with sodium restriction. A persistent, loud pericardial rub, approaching grade V in intensity, respiratory rates of 30 to 36 per minute, and a gradual rise on the fifth day of the temperature to 103 F. orally were noted. Clinical evidence of cardiac tamponade was diligently sought but not found. The third heart sound was no longer audible after the second day. Arm-to-tongue circulation time was 19 seconds on the fifth day. On an empirical basis rather than through recognition of the patient's true affliction, parenteral hydrocortisone and maintenance prednisone ("Meticorten") therapy were initiated at the height of the





Fig. 1. Electrocardiographic pattern 36 hours after occurrence of acute chest pain of prolonged duration.

^{*}Serum glutamic oxalic transaminase.

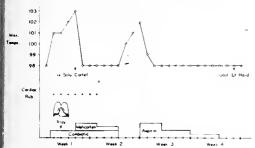


Fig. 2. Illustrating clinical course of a 63 year old male after acute myocardial infarction.

fever on the fifth day and the latter drug was administered through the twelfth day. Anticoagulant therapy was continued. A dramatic clinical response ensued (fig. 2), including prompt disappearance of fever, clearing of lung signs, pericardial friction sounds, tachypnea, and chest pain over a 36 hour period.

Signs pointing to the Dressler syndrome were not recognized until fever recurred unaccompanied by cardiac or pulmonary signs after steroid therapy had been discontinued on the twelfth day. Because this man had had persistent hallucinations during the first hospital week, we had to consider steroid therapy as a possible precipitating "toxic" agent. Tests for LE cells and heterophile and brucella antibodies were negative. Blood platelets numbered 192,000, white blood cells, 10,200 with a normal differential; the coagulation time was four minutes; serum globulins measured 3.1 Gm. per 100 cc., and serum albumin 4.2 Gm. per 100 cc. Serum electrophoresis suggested the globulin rise had occurred in the alpha 2 and gamma fractions, After 48 febrile hours we realized that this complication resembled the symptom complex reported by Dressler, but in view of the patient's hallucinations began therapy not with steroids but with acetylsalicylic acid in decreasing ratios over the ensuing 12 days.

The clinical response was prompt and sustained even after cessation of treatment. No pleural or pericardial rubs developed, nor any adventitious signs suggesting pneumonitis. Blood pressures and electrocardiograms remained static. Convalescence was without incident except for an attack of gouty arthritis occurring at the end of the fourth hospital week. The pa-

tient continued to evidence an organic psychosis and died in another city (while institutionalized) without autopsy 16 months later

Comment

Two recent reviews of this syndrome form the basis of our present knowledge and our discussion. The physician treating the patient with recent myocardial infarction should be aware that a rare type of pleuro-pericarditis accompanied by chest pain, leukocytosis, and often pneumonitis and hemoptysis, may follow myocardial Usually this syndrome occurs necrosis. within two weeks of the onset of infarction. Its course may be protracted for weeks or months, and like the postcommissurotomy syndrome and benign idiopathic pericarditis, to which it may be related, relapses are frequently experienced. Dressler has seen recrudescence up to two years after onset when steroid therapy was discontinued(8).

The essential diagnostic features include, first, a prolonged fever after myocardial infarction, or abrupt temperature rises during convalescence from myocardial infarction, along with pleuro-pericardial pain. An audible cardiac rub was heard in three fourths of Dressler's patients. Secondly, physical and roentgen signs of pleural or pericardial effusion provide additional clues, noted in two-thirds of the Dressler series. Thirdly, pneumonitis, rarely with hemoptysis, occurs in one third of the cases. The pleuritic and pericardial characteristics of the pain and the absence of serial electrocardiographic changes serve to rule out extension of myocardial infarction as a cause of these symptoms. That the subject has not sustained pulmonary infarction is usually clear because of the presence of pericarditis. If roentgenograms show a large cardiac silhouette, serial views will indicate pericardial effusion rather than cardiac enlargement as causative.

Laboratory findings, including leukocytosis, an increased sedimentation rate, and negative blood, chest and pericardial fluid cultures, are non-specific. The serum protein changes in our patient were not striking enough to be considered as diagnostically or etiologically helpful.

Fortunately the prognosis of the patient with this syndrome seems to differ little

from that of the underlying infarction, except that pericardial hemorrhage is presumably a danger if anticoagulants are not withheld when the pericarditis appears. Patient 4 in Dressler's most recent paper of suffered a fatal pericardial hemorrhage which the author attributed to anticoagulant therapy.

The etiology of this syndrome is as obscure as that of two closely related disorders, namely idiopathic nonspecific pericarditis and post-commissurotomy syndrome. Dressler raised the question of sensitization to autoantigens of myocardial origin as a possible cause. It seems clear that neither bacterial infection nor reaction to anticoagulant drugs can be implicated in cases on record⁽⁶⁾.

In the case we have reported, the patient was maintained throughout on anticoagulants because of our ignorance of their inherent danger and our delay in making the correct diagnosis. Dressler believes that adrenal steroid therapy is best reserved for severe cases of post-myocardial infarction syndrome. In retrospect, we believe our patient's condition warranted such therapy, but we confess that our use of cortisone derivatives was empirical. Perhaps because of an underlying psychosis, this patient appreciated only moderate pain with his initial infarction, and slight pain with his first episode of pneumonitis and pericarditis. (Nursing notes contain no record of his receiving any narcotic during his hospital stay.) He complained of no discomfort with his second episode of fever 12 days after admission. The decision to use salicylates was made at this juncture, lest steroids in suppressive doses aggravate the patient's mental abberations. His clinical response was satisfactory. Whether organic brain disease or medication altered central appreciation of pleuro-pericardial pain with his second febrile spike or whether the serous tissue reaction was minimal is unknown, since roentgenograms were not taken and physical signs of such reaction were absent. Dressler noted prompt defervescence in one case after salicylate therapy(2), but in his latest report he mentions salicylates only as analgesics for chest pain(6). It was our impression that the large doses of salicylates were of therapeutic value in our patient's second bout of post-myocardial infarction syndrome: and for this reason we suggest their clinical trial when steroids are contraindicated.

Since encountering this case we have not been aware of a similar event in other patients following cardiac infarction. Another review of a large series of patients should be made to confirm that this pleuro-pericardial reaction following acute myocardial infarction occurs in 3 to 4 per cent of all cases as Dressler has indicated occurred on his service.

Summary

An unusual, oft-relapsing pleuro-pericardial reaction attended by fever, central chest pain, and sometimes pneumonitis, occurred in an elderly man during convalescence from acute cardiac infarction. This syndrome has been studied with care by Dressler but confirmed by few other authors. We urge others to aid in determining how frequently this post-myocardial infarction syndrome of Dressler occurs.

Addendum

Since submission of this manuscript 4 more cases of this disorder have been encountered over a short observation period by Weiser and his associates. (Weiser, N. J., Kantor, M., and Russell, H. K. "Post Myocardial Infarction Syndrome" Circulation 20:371, 1959).

References

- Dressler, W.: A Complication of Myocardial Infarction Resembling Idiopathic Recurrent Beniga Pericarditis (Abstract of paper read before the twenty-eighth annual session, American Heart Association), Circulation 12:697 (Oct.) 1955 (Abs.).
- Dressler, W.: A Post-Myocardial Infarction Syndrome: Prelimicary Report of a Complication Resembling Idiopathic, Recurrent Benign Pericarditis, J.A.M.A. 160:1379-1383 (April 21) 1956.
- McGnire, J., and others: Nonspecific Pericarditis and Myocardial Infarction: Their Differential Diagnosis, Circulation 14:874-882 (Nov.) 1956.
- Mandel, W., and Johnson, E. C.: Pleuropericardial Effusion Following Myocardial Infarction, Am. Heart J. 53:145-149 (Jan.) 1957.
- Stein, I., and Weinstein, J.: Pericarditis Complicating Myocardial Infarction, Am. Heart J. 54:146-151 (July) 1957.
- Dressler, W.: The Post-Myocardial-Infarction-Syndrome: A Report on Forty-four Cases, Arch. Int. Med. 103:28-42 (Jan.) 1959.
- Dressler, W.: The Postmyocardial Infarction Syndrome. Recurrent Pericarditis, Pleurisy, and Pneumonitis, 7:102-104 (Nov.-Dec.) 1958.
- Dressler, W.: Flare-up of Pericarditis Complicating Myocardial Infarction After Two Years of Steroid Therapy, Am. Heart J. 57:501, 1959.

An Approach to the Problem Of Early Simple Glaucoma

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In approaching the problem of the patient with early simple glaucoma, it might be in order to define what is meant by "early simple glaucoma." Our connotation is that the patient has an intraocular pressure of no more than 30 mm. of mercury as measured by the Schiotz tonometer, with either minimal or no field changes due to glaucoma, and an open filtration angle.

This brings up the somewhat controversial point as to whether the diagnosis of simple glaucoma can be made in the absence of visual field changes. We believe that it can, on the basis of tension, tonographic data, and, especially, provocative tests in conjunction with tonography. We have had several cases which we diagnosed before visual field loss, in which typical visual field changes due to glaucoma subsequently developed.

Case Detection

The first problem to be confronted in the approach to the patient with early simple glaucoma is that of identifying him. We have set up a specific routine for case-finding to follow in patients coming to our office for "routine examination."

The first step is taking the history. We ask specifically about any family history of glaucoma or blindness which may be due to glaucoma. Since there are likely to be no symptoms in early simple glaucoma, we feel that this information is probably the most important aspect of the history.

The next step is to make a careful note of the optic nerve head. Certain symbols indicating the depth of the cup, the sharpness of the margins of the cup, and the amount of overhang of the cup are noted. We have found it difficult to differentiate physiolgic cupping from glaucomatous cupping and also to detect minor changes in the cup on later examinations. It is a distinct aid to have fairly specific sketches of the discs rather than mere description or statements such as "no glaucomateus cupping."

Tonometry is the next important step. This procedure is always done on any patient 35 years of age or older, on any patient whose cup has made us at all suspicious of simple glaucoma, and on any patient who has any family history of glaucoma. Tonometry is the most effective tool we have to pick up cases of early glaucoma.

In 18 months Hildreth(1) found 97 eyes with normal discs, open angles, and normal visual fields which had what he called "border-line tension." Among these there were 69 with glaucoma, and only 20 which were found to be normal at the end of a follow-up period of 6 to 18 months. Of the 69 eyes with glaucoma, treatment was started on 21. Only one of this group suffered field loss, while 26 of the 48 untreated eyes lost field during the follow-up period. Thus in a period of 18 months one physician found some 30 patients with early glaucoma who otherwise would have been missed without tonometry. Hildreth did not specifically state what he considered a "border-line tension." We consider a scale reading of 3.5 or less on the Schiotz tonometer suggestive of an abnormal intraocular pressure.

A tachystoscopic field test is the next step in our routine screening process. This can be done very easily and quickly by the office nurse or technician. The test has proved valuable by occasionally enabling us to find patients with abnormal visual fields who eventually were found to have definite glaucoma although during routine tonometry they showed tensions within the normal range.

Diagnosis

If any of the above tests suggest that this patient may have glaucoma, we then attempt to make a definitive diagnosis. For this purpose we ask him to return to the office at a later date. The second examination also follows a very definite routine. The first test done is the visual field on the tangent screen. We eventually attempt to use a 1 mm. test object at 1,000 mm. on all

patients, although this rule has to be altered with certain patients who are "difficult field subjects." We use the Harrington "black light" in conjunction with fluorescent test objects on a Gunkel screen. Although this method may not be quite as sensitive as more standard procedures, we believe that this disadvantage is outweighed by its advantages. In our hands these advantages are fewer "false positive" field defects and better, more accurate, and more repeatable patient response. By this method we have found a high correlation between the field defects taken with the 2/1000 white test object and those picked up on the tachystoscopic screener. Tonography is then done on all of these patients, followed by gonioscopy.

Not infrequently all studies up to this point are within normal limits. If this is true, we perform a water-drinking provocative test at a later date. We do this by determining the baseline tension and having the patient drink 1000 cc. of water, and then checking the ocular tension every 15 minutes. At the end of 45 minutes or an hour tonography is done. We consider that the test is positive for glaucoma if there is a rise in the intraocular pressure of 8 mm. or more of mercury; if there is a rise in the intraocular pressure to three scale readings or less on the Schiotz tonometer, or if there is significant change in tonographic tracings. We consider these latter changes significant if the facility of outflow (C-value) drops to a definitely abnormal value such as 0.15 or below, or if it drops significantly from previously established levels. We have also found the ratio of the initial pressure (Po) divided by the facility of outflow (C-value), as defined by Becker(2), of extreme value. This purely arbitrary ratio takes into account two important physiologic conditions of the eye; namely, the pressure and the facility of outflow. A ratio above 100 is considered abnormal.

There are two points here that I believe should be emphasized. Once a person has become a "glaucoma suspect" in our clinic, it may take several months to establish a diagnosis of glaucoma. We have found it easier to make the diagnosis of glaucoma than to refute it definitely. The second point of emphasis is our belief that the diagnosis of glaucoma by use of tonometry,

tonography, and provocative tests can be made before functional loss occurs. This, of course, is when the diagnosis should be made, since therapy can then be directed toward maintaining normal vision and normal fields. I believe it is generally conceded that treatment is most efficacious during this period.

Therapy

I would like to emphasize that the treatment to be discussed in this section is that used in early, but established, glaucoma. Pilocarpine is still the usual treatment for simple glaucoma. Weaker solutions, usually starting with 1 per cent, are used initially and increased up to 4 per cent as deemed necessary and as discussed in the subsequent section. Of course other drugs such as eserine are used. In glaucoma patients we frequently use pilocarpine drops in conjunction with pilocarpine salve at bedtime or occasionally with eserine salve because of its longer effect. We also use 1½ per cent carbamylcholine in phemerol in patients who become "pilocarpine-fast."

Recently we have frequently been using 2 per cent epinephrine bitartrate. This is one of the older drugs used in glaucoma therapy, but until recently it apparently was used infrequently. In a recent study, Becker and Ley(3) found that the mode of action of this drug is to suppress the secretion of aqueous. This action has been an extremely useful adjunct in the treatment of simple glaucoma, and in our hands is used in conjunction with pilocarpine. In this way we hope that the pilocarpine will improve the facility of outflow, while epinephrine bitartrate will suppress the aqueous formation. We have also found that epinephrine bitartrate used in conjunction with pilocarpine seems to cut down the amount of ciliary spasm and the resultant myopia that is so annoying to patients on pilocarpine therapy. Our patients have complained somewhat of a local irritation due to the 2 per cent epinephrine hydrochloride, but since this drug is used only once a day, they have usually come to tolerate it without too much complaint.

Carbonic anhydrase inhibitors are extremely useful drugs in the treatment of simple glaucoma, even on a prolonged basis. Our experience would agree with that of

others that none of the newer drugs offer any real advantage over acetazolamide (Diamox).

I wish to emphasize that in early simple glaucoma, medical therapy is pushed to extremes, as will be discussed later, and surgical intervention is avoided except where the medical treatment is failing, as evidenced by progressive loss of visual field. In surgical therapy, one of the most recent aids that we have found to be of value is Scheie's (4) new filtering procedure, using coagulation of the wound edges. We have not yet had wide experience with this procedure, but in the few cases where it has been used, it has given excellent filtration.

Prognostic Criteria

In this section I include the step necessary to evaluate the results of therapy. After all, the crux of any treatment for glaucoma is whether it is preserving the vision of the particular individual who is receiving it. We follow these patients at intervals of approximately four months, usually varying the appointments from morning to afternoon so that any diurnal variation may be detected. We frequently time examinations at an hour when medication is due to see if the therapy is adequate at this crucial time. At each visit the optic discs are carefully compared with the previous sketches, and the ocular tension is also determined. The visual fields are recorded personally at each visit. We feel that it is important to have the same examiner at each visit, if the presence or absence of field changes is to be valid. If progression of the visual field loss is apparent, we check meticulously for possible non-glaucomatous causes, such as extreme miosis, lenticular opacities, or other external factors such as lid drooping, glasses frames, and the like.

Tonography is done at each follow-up visit. We have found this to be second in importance only to visual fields in following patients with early simple glaucoma. As pointed out by Becker(5) and more recently by Roberts (6), normalization of the C-value gives a much better prognosis for visual fields than normalization of the ten-

sion alone.

It might be of interest at this point to compare the various criteria of control of glaucoma over a three year period (5). Using certain arbitrary criteria for excellent control—primarily no loss of visual field and

no recorded tension of over 24 mm. of mercury on the Schiotz tonometer—Becker found that by maintaining the ratio of the tension over the facility of outflow at 100 or less, 90 per cent of the cases were "controlled." If the scale reading of 4 (20.4 mm. of mercury) on the Schiotz tonometer is used as a criteria for control, then 74 per cent of his cases were "controlled" on therapy over a three-year period. If only a scale reading of 3 (24 mm. of mercury) is used, however, then only 50 per cent of his cases were "controlled". Since tonography is not widely available, it might be pointed out that the simple expedient of using a scale reading of 4 (20.4 mm. of mercury) instead of 3 increases the chance of control by 25 per cent. At this point I wish to emphasize that in our opinion the lack of return of the facility of outflow to normal on the normalization of the pressure over the facility of outflow value is not an indication for surgery. We do believe, however, that it is an indication to increase the medical therapy and increase the vigilance about the visual fields. Surgery is done only in cases which show a visual field loss during maximum tolerable medical therapy. In our hands maximum tolerable therapy and I emphasize the word tolerableusually consists of 4 per cent pilocarpine or its equivalent four times a day, 2 per cent levoepinephrine hydrochloride once or twice a day, and Diamox in doses that do not cause digestive upsets or intolerable paresthesias.

Summary

No attempt has been made to present any original work in this discussion. Instead we have outlined techniques of case-finding, diagnosis, and treatment that we use in dealing with the problem of early simple glaucoma.

References

1. Hildreth, H. and Becker, B.: Routine Tonometry, Am. J. Ophth. 43:21-23 (Jan.) 1957.

2. Becker, B., and Christensen, R. E.: Water Drinking and Tonography in the Diagnosis of Glaucoma, Arch. Ophth. 56:321-326 (Sept.) 1956.

3. Becker, B., and Ley, A. P.: Epinephrine and Acetazolamide in the Therapy of the Chronic Glaucomas, Am. J. Ophth. 45:639-643 (May) 1958.

4. Scheie, H.: Peripheral Iridectomy with Scleral Cautery for Glaucoma, Arch. Ophth. 61:291-297 (Feb.) 1959.

6. Becker, B.: The Prognostic Value of Tonography in the Miotic Therapy of Chronic Simple Glaucoma, Am. J. Ophth., 46:11-14 (July) 1968.

6. Roberts, R.: Tr. of the Third Conference on Glaucoma.

Edited by Frank Newell, p. 203.

The Position of the Internist and Other Non-Surgical Specialists in the Pattern of Medical Care

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DURHAM

It is a pleasure to come here as a representative of the North Carolina Society of Internal Medicine. This new group was organized in 1955, with all the aims and purposes of the American College of Physicians and with the broad aim of promoting an understanding between board-certified specialists in internal medicine and other nonsurgical practitioners who are recognized at the community level as performing services typical of specialists in their field. Real progress has been made in improving our own understanding of the position of a non-surgical specialist in the entire pattern of medical care. Our attendance at these meetings has improved, and there is more interest in activities at the county level.

In general, our interest in the problems of medical care has been welcomed, and our activities are arousing real interest in other states. Contrary to some of the statistics we read, it seems that North Carolina is far from being regarded as a backward state. As president of a new national society of internists during the past year, with an opportunity to compare the activities of physicians in different states, I have never needed to apologize for the medical situation in North Carolina.

I am here to report my personal experiences derived from nationwide contacts during the past two years, and to express my conviction that it is not too late, although the time appears to be growing short, to break down some of the fences which have been erected within the medical profession by a mistaken concept of board certification. According to this concept, board certification implies that any particular specialty group can determine that some doctors in its field are "first class" and that all others must be regarded as "second class." Qualification by a specialty board is easy to recognize on paper, but

the true and actual recognition of services performed by a specialist comes at the level of patient care as it has been established in the community.

As licensed physicians, we have the responsibility of serving our particular community in the best possible way, according to community standards. A well qualified practitioner in a suburban area close to Charlotte or Asheville might reasonably hesitate, because of his proximity to a medical center and possible repercussions, to perform a spinal puncture for diagnosis alone as distinct from the same procedure done as an acutely needed therapeutic measure. The same test, however, is expected to be done by every physician in a rural area. It is the community, rather than the Medical Society of the State of North Carolina or any society of specialists, which determines what type of doctor will perform a specific service.

Extension and Recognition of Specialty Services

As our ability to care for the public has improved, the services of those trained in surgery and the surgical specialties have been extended. This extension has been greatly simplified by the fact that detailed and explanatory schedules for surgical operations can easily be recognized by the hospital in which they are performed, as regards both the quality of the service and its cost. Fee schedules may be either of the indemnity type or may specify that the service will be performed for a prearranged fee where the actual performance can be shown and documented.

The extension of adequate surgical services and the recognition of the surgical specialties in smaller communities has been promoted by the fact that these fee schedules for a particular service can be recognized wherever the service is performed, and whether or not it is performed by a certified specialist.

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^{*}President of the American Society of Internal Medicine.

In an effort to improve and broaden the quality of medical care available to the public, many non-surgical specialists, including internists, have established themselves as specialists and have been able to command recognition of their services by setting fees commensurate with the additional time and skill involved in making a complete diagnostic survey of a complicated or confusing non-surgical problem. The services of the internist, and of other non-surgical specialists, are now clearly regarded as a necessary part of medical care.

Relative Value Theory of Prepaid Medical Care

Speaking in general, it should now be evident to every licensed practitioner that the acceptance of the principle of prepaid medical insurance is absolutely necessary if the private practice of medicine as it is known today is to continue to offer the people of this country the highest type of medical care available anywhere. Many informed people are convinced that it is only a matter of time-perhaps 10 years, perhaps more-until we have some type of governmental medical coverage which will be as satisfactory to the average American citizen as the National Health Service has been to the average British subject. It is our problem to design a pattern of prepaid medical care which will be controlled by the physician rather than by the government, and the importance of the services of the non-surgical specialist must be recognized in this pattern if it is to succeed.

This fact was recognized by the American Medical Association in 1955 by the appointment of a Committee on Medical Service (Dr. Warde B. Allen of Baltimore, chairman) to study, among other things, "means of securing better recognition of diagnostic and non-surgical services to the patient." During its first year of study this Committee became interested in the Relative Value Theory, which was being tested in California and Iowa, and examined with great interest in Michigan. The committee arranged for a year of study by the Society of American Actuaries, whose report was received in Philadelphia in December, 1957, and the American Medical Association has now asked that each state society conduct a similar study. Although the A.M.A. can never direct its component societies, this

action strongly indicates that whether physicians approve or disapprove, the fact remains that we are going to live and work with a schedule of fees with relation to a significant proportion of our practice, from now on. The question remaining is a challenge to the medical profession in each state.

The present hodgepodge of lengthy and poorly standardized schedules for surgical procedures was developed independently by some 73 completely autonomous Blue Shield organizations and hundreds of insurance companies. Most of these schedules include only token coverage for any type of nonsurgical care, however it is rendered. Must this represent the best thinking of the American medical profession, or can we establish, with the use of the "relative value" theory, a set of basic schedules that will allow for reasonably accurate predictions as to the cost of the entire pattern of medical care, now and in the future?

It is clear to everyone here that, although almost all Blue Shield and commercial fee schedules covering medical and surgical services are out of balance and fail to recognize the time and skill involved in many non-surgical procedures, the physicians who now perform these procedures are being recognized and recompensed in such a way that personal gain is not a factor in their concern for the future. Our board-qualified colleagues in the surgical specialties are equally concerned that in the future the non-surgical specialist be able to maintain the present quality of medical care and that his services continue to be recognized. Many general practitioners now schedule appointments for detailed study of certain problem cases and charge appropriate fees. They understand that the development of a fee schedule for specified non-surgical services will be helpful in the future.

It is reasonable to suppose that the board-qualified specialist in North Carolina who customarily takes a complete history and does a complete physical examination on his patients considers that, although his net income is lower on the average than that of a member of the Academy of General Practice or of a board-qualified surgeon or surgical specialist, he is adequately compensated by the circumstances of his practice and the fact that his patients

recognize that his services require additional time and skill. As I have said, the present situation in North Carolina is not open to any major criticism in comparison with that of other states.

It must be recognized, however, that organized medicine in this country, from the county society to the American Medical Association, has failed to make a constructive approach to the social and economic aspects of health and medical care, particularly as they relate to the problem of extending prepayment programs to cover the cost of full medical care. The board-qualified internist, pediatrician, and neurologist have often failed to recognize the difference, economically speaking, between the patient who actually requires specialized care and the patient seeking elective medical investigations for such nuisance complaints as hay fever, headache or indigestion, who should assume a considerable part of the cost. It is entirely reasonable that board qualifications should be recognized in some instances.

Definition of services

It should, however, be understood that the relative value theory only recognizes the characteristic services of a specialty, and must specify that any physician who shows that he has performed them may be equally compensated. The lack of an adequate definition of these services in a fee schedule was a stumbling block until the publication, under the direction of General Paul Robinson, of the second proposed Medicare contract with the United States Government. As many of you know, this contract defined, clearly and in considerable detail, a series of non-surgical procedures which would allow evaluation on either a unit or dollar basis. The adoption of such a descriptive schedule will greatly simplify the development of a set of relative value fee schedules.

Need for a Relative Value Study in North Carolina

So far in this discussion I have stressed the fact that there need be no apology for the present intraprofessional relationships in North Carolina, and that, allowing for variations in community standards, our pattern of medical care is probably above the national average as it relates to the costs of adequate medical services at all

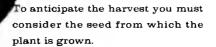
levels in the community. I have indicated the same doubts you all experience as to the realistic values of our present Blue Cross contracts with regard to the services of a non-surgical specialist, and I have pointed out that the same difficulties are present in other states and in all hundreds of fee schedules which have been promulgated by Blue Shield and commercial insurance companies. We are all aware that until now organized medicine has failed to offer a balanced type of relative value schedule, specifying the details of services characteristic of nonsurgical specialists. Such services can be recognized in hospitals, just as surgical procedures are recognized, and can be recognized by the fiscal agents of insurance programs if they are clearly specified and if adequate reports are included with a claim for a specific service.

There is no reason for North Carolina to adopt the findings of any other state in connection with a relative value study. We are in an ideal position to secure the necessary information for a study which will have a great impact on the entire picture of organized medicine. The best way to assure the future status of the whole pattern of medical care in North Carolina would be to define accurately each and every service that is now being furnished in North Carolina by a doctor of medicine, to determine by appropriate questionnaires what fees are being collected for such services in various areas of the state, and to analyze this material on a statistical basis. There should be no attempt to compare medical services with those of surgery, radiology, laboratory technology, and pathology in determining the initial relative values, and the entire program should be based on findings from North Carolina rather than on conclusions from other state surveys.

In the survey there should be emphasis on an evaluation of the proportionate relationship between charges made by individual physicians and the total cost of medical care to their patients because of increased costs of hospital care, drugs, and special investigative procedures.

Summary

To revert to the title of this address and the reasons for my appearance on this



BUALITY.

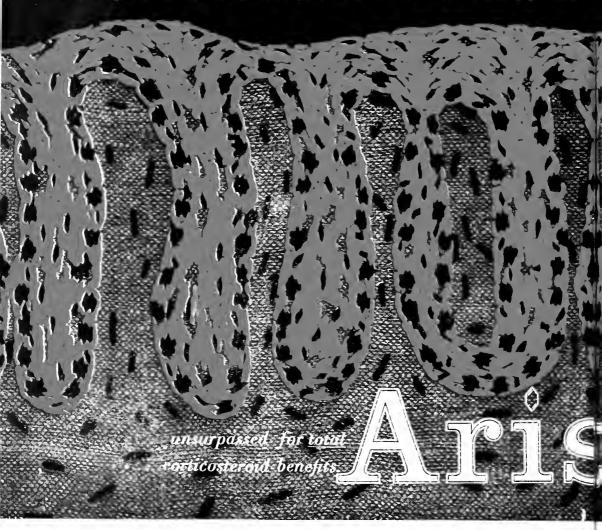
It is human nature to ask: "What's behind it?"The fact that our nation's doctors stand behind Blue Shield, through their local medical societies, is certainly an important reason for its widespread acceptance. One doctor summed it up this way: "The public will have faith in Blue Shield so long, and only so long, as we the doctors have faith in it and continue to endorse it." **BLUE SHIELD**



HOSPITAL SAVING ASSOCIATION

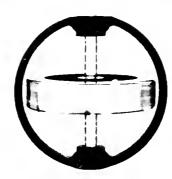
CHAPEL HILL, NORTH CAROLINA

in allergic and inflammatory skin disorders (including psoriasis

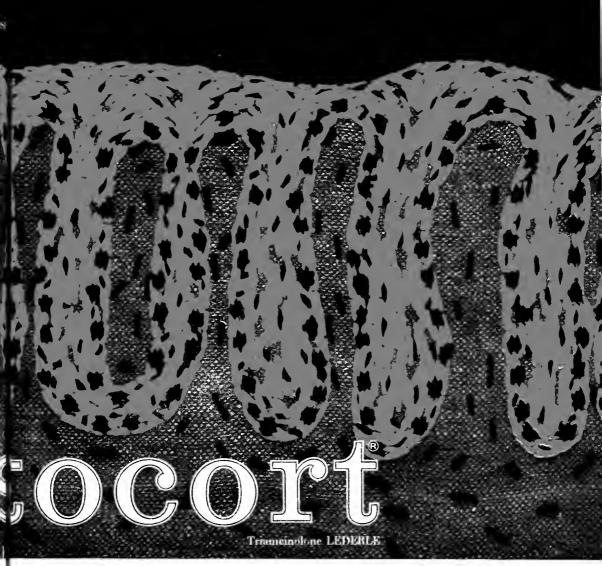


Substantiated by published reports of leading clinicians

• effective control of allergic and inflammatory symptoms



• minimal disturbance of the patient's chemical and psychic balance balance



At the recommended antiallergic and antiinflammatory dosage levels, ARISTOCORT means:

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- · virtual freedom from potassium depletion
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- · no voracious appetite no excessive weight gain
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E. W.: 1.4.M.4. 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: Conn. Med. 22 822 (Dec.) 1958. 3. Friedlaender, S., and wood, H.: Conn. Med. 27 822 (Dec.) 1988. 3. Friedlaender, S., and Friedlaender, A. S.: Antibotic Med. & Clin. Ther. 5:315 (May) 1988. 4. Segal, M. S., and Duvenci, J.: Bull. Tufts N.E. Medical Center 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, J.A.M.4. 169:1063 (March 7) 1958. 6. Hartung, E. F.: J. Florida Acad. Gen. Practice 8:18, 1957. hartung, E. F.; J. Trorial Acad. Gen. Fractice 8:18, 1991.
 Rein, C. R.; Fleischwager, R.; and Rosenthal, A. L.; J.A.M.d.
 165: 1821 (Dec. 7) 1957.
 McCavack, T. H.; Clin. Med. (June)
 1959.
 Fresberg, R. H.; Rerntsen, C. A., and Hellman, L.;
 Arthituts & Rheumatism 1:215 (June)
 1958.
 10. Hartung, E. F.;
 J.A.M.d., 107:973 (June 21)
 1958.
 11. Zuckner, J.; Ramsey, R. H.; J.4.M. 4, 167-973 (June 21) 1958, 11, Zuckner, J.; Ramsey, R. H.;
Cacolol, C., and Gantner, G. E.; Ann. Rehemat. Dis. Jr 1398 (Dec.)
1958, 12, Appel, B.; Tye, M. J., and Leibsolm, E.; Antibiotic Med.
& Chn. Ther. 5:716 (Dec.) 1958, 13, Kall, F.; Canad, M.-J.,
79-400 (Seph.) 1958, 14, Mullins, I. F.; and Wilson, C. J.; Tevas J.
Med. 54:618 (Sept.) 1958, 15, Shelley, W. B.; Harun, J. S., and
Pillsbury, D. M.; J.-AM, J. 61:799 (June 21) 1958, 16, DuBois,
E. L.; J. 4.M. A. 167:1590 (July 26) 1958, 17, M. Gavark, T. H.;
Kao, K. T.; Leske, D. A.; Bauer, H. G., and Berger, H. E.; Am.
J. M. Sc. 250:120 (Dec.) 1958, 18, Council on Drugs J.-J.M.A.
169:257 (January) 1959.

References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman,



(Ledarlo) LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

Concerning Your Health and Your Income

A special report to members of the Medical Society of the State of North Carolina on the progress of the Society's Special Group Accident and Health Plan in effect since 1940

PROUDLY WE REPORT 1959

AS OUR MOST SUCCESSFUL YEAR IN SERVING YOUR SOCIETY.

During the year we introduced a NEW and challenging form of disability protection. There has been overwhelming response on the part of the membership.

Participation in this Group Plan continues to grow at a fantostic rate.

1960

is our 20th year of service to the Society. It is our aim to continue to lead the field in providing Society members with disability protection and claim services as modern as tomorrow.

SPECIAL FEATURES ARE:

- 1. Up to a possible 7 years for each sickness (no confinement required).
- 2. Pays up to Lifetime for accident.
- 3. New Moximum limit of \$650.00 per month income while disabled.

All **new** applicants, and those now insured, who are under age 55, and in good health, are eligible to apply for the new and extensive protection against sickness and accident.

OPTIONAL HOSPITAL COVERAGE: Members under age 60 in good health may apply for \$20.00 daily hospital benefit — Premium \$20.00 semi-annually.

Write, or call us collect (Durham 2-5497) for assistance or information.

BENEFITS AND RATES AVAILABLE UNDER NEW PLAN

Accidental Death	Dismemberment	COST UNTIL AGE 35		COST FOR AGES 35 TO		
Coverage	Loss of Sight, Speech or Heoring	Accident ond Sickness Benefits	Annuol Premium	Semi-Annuol Premium	Annual Premium	Semi-Annue Premium
5,000	5,000 to 10,000	50.00 Weekly	\$ 78.00	\$ 39.50	\$104.00	\$ 52.50
5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.50
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.50
5,000	12,500 to 25,000	125.00 Weekly	186.00	93.50	248.00	124.50
5,000	15,000 to 30,000	150.00 Weekly	222.00	111.50	296.00	148.50

*Amount payable depends upon the nature of the loss as set forth in the policy.

Administered by

J. L. CRUMPTON, State Mgr. Professional Group Disability Division Box 147, Durham, N. C.

J. Slade Crumpton, Field Representative

UNDERWRITTEN BY THE COMMERCIAL INSURANCE COMPANY OF NEWARK, N. J.

Originator and pianeer in professional group disability plans.

platform, it appears that the non-surgical specialist is reasonably satisfied with his present position in the pattern of medical care, as are the younger men now in training for these positions. Present social and economic trends, however, indicate that a careful and detailed evaluation of the total picture of medical care in North Carolina is urgently needed in order to establish a "relative value" basis for a realistic view of the future.

If a balanced pattern of total medical care is to be maintained, the types of services performed by non-surgical specialists must be described and assigned reasonable relative values, just as has been done for the types of services performed by surgical specialists.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION

STATEMENT OF PRINCIPLES OF ETHICAL DRUG PROMOTION

(Adopted by the P.M.A. Board of Directors, May 24, 1958)

WE, members of the Pharmaceutical Manufacturers Association, recognizing our responsibilities and obligations to promote the public welfare and to maintain honorable, fair, and friendly relations with the medical profession, with associated sciences, and with the public, do pledge ourselves to the following statement of principles:

- Prompt, complete, conservative and accurate information concerning therapeutic agents shall be made available to the medical profession.
- 2. Any statement involved in product promotional communications must be supported by adequate and acceptable scientific evidence. Claims must not be stronger than such evidence warrants. Every effort must be made to avoid ambiguity and implied endorsements. Whenever market, statistical or background information or references to unpublished literature or observations are used in promotional literature, the source must be available to the physician upon request.
- 3. Quotations from the medical literature or from the personal communications of clinical investigators in promotional

- communications must not change or distort the true meaning of the author.
- 4. If it is necessary to include comparisons of drugs in promotional communications, such comparisons must be used only when they are constructive to the physician and made on a sound professional and factual basis. Trademarks are private property that can be used legally only by or with the consent of owners of trademarks.
- 5. The release to the lay public of information on the clinical use of a new drug or on a new use of an etablished drug prior to adequate clinical acceptance and presentation to the medical profession is not in the best interests of the medical profession or the layman.
- All medical claims and assertions contained in promotional communications should have medical review prior to their release.
- 7. Any violation of these principles brought to the attention of the President of the Pharmaceutical Manufacturers Association shall be referred by him to the Board of Directors.

New Synthetic Drug Effective Against Varied Bacterial Infections

Of 466 patients with varied bacterial infections treated by physicians throughout the country who have participated in a recent study, 61 per cent were cured and 21 per cent improved by therapy with a new synthetic antibacterial agent called Altafur (furaltadone, Eaton), it is reported by Drs. Paul J. Christenson and Charles H. Tracy in Current Therapentic Research (2:1, 22-29, Jan. 1960). Altafur is a member of the nitrofuran class of drugs, which are neither antibiotics nor sulfonamides.

Some 240 patients in the study "had failed to respond to previous therapy with other antibacterial agents, and, of these, 54 per cent were cured and an additional 24 per cent improved with furaltadone," the physicians state.

The study includes 266 cases in which Staphylococcus aureus was the causative organism. Some "65 per cent were cured and a further 19 per cent improved" with furaltadone.

The physicians note that "no reports of unusual side effects" were brought to their attention. They add that furaltadone "apparently interferes with the oxidation of alcohol" and "patients being treated with furaltadone, and for seven days thereafter, should refrain from ingesting alcohol in any form."

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APRIL, 1960

PILLS AND POLITICS

The day after sulfapyridine—the first sulfonamide found effective against the pneumococcus-was released for sale on prescription, a doctor prescribed 50 tablets for a patient who had just developed lobar pneumonia. It then cost 50 cents a tablet. Later when one of the family came in to pay the bill, he commented on the excessive cost of the prescription. He was reminded that the patient's temperature was normal the second day of the disease; that the doctor made only three visits to the house before discharging the patient; whereas a few years before the same patient with the same disease was in the hospital for three weeks, with nurses around the clock for 10 days. The critic of the high cost of the new drug then agreed that it would have been cheap at a much higher price.

Now sulfapyridine has been replaced by other sulfonamides which are far superior but which are quite inexpensive.

If the cost of penicillin had remained at its first level, even moderately well to do families could not afford the enormous doses now prescribed. The same could be said of insulin and of many other modern drugs. For the development of these lifesaving remedies and for their being within the reach of most patients, we can thank the pharmaceutical houses now under criticism by the Kefauver Committee. Undoubtedly the so-called wonder drugs have been prescribed entirely too freely, and their overuse has added greatly to the cost of medical care. They have, however, saved thousands of lives when they were really needed.

One of the most deep-seated traits of human nature is the desire for a scapegoat to blame for undesirable events. While the cost of medical care has not increased nearly as much as the cost of living generally, it has been resented by the public.

Senator Kefauver's Committee, in its sweeping indictment of the pharmaceutical industry, ignores the enormous amount of fruitless research that has preceded the production of remedies that have revolutionized the practice of medicine. It has been estimated that of chemical substances tested for therapeutic use, not more than 40 out of 1,900 showed enough promise for a clinical test. Dr. Austin Smith has estimated that since 1947 the pharmaceutical industry has spent about one billion dollars in research alone

It is true that the cost of some new drugs seem excessive, but it is equally true that competition between manufacturers — and possibly some humanitarian instinct — has resulted in tremendous reductions in price.

Soon after Dr. Austin Smith, former editor of the Journal of the A.M.A., became president of the Pharmaceutical Manufacturers Association, the Association adopted a statement of principles of ethical drug promotion which pledges them to "maintain honorable, fair, and friendly relations with the medical profession, with associated sciences, and with the public." It is unfortunate that this statement of principles has not been circulated as widely as have the unfair charges made by the Kefauver Committee.

EDITORIALS 153

HEALTH AND INCOME

In its Bulletin for March, the Health Information Foundation gives an interesting comparison of the mortality rate from 1930 through 1957 in high-income and low-income states. In 1930 the death rate in the 10 states with the lowest income was 13 per cent greater than in the 10 with the highest income (140 per 1,000 as compared with 124 per 1,000). This gap has gradually narrowed until in 1957 the difference was only 1 per cent (84.2:83.75). The national death rate has dropped by 37 per cent.

Of further interest and significance is that for the older age group—65 and over—the mortality is lower in the low-income states.

The rate for certain disease is noteworthy. The mortality from heart diseases, cancer, diabetes, suicide, vascular lesions, and accidents is significantly higher in the high-income states. Influenza, pneumonia, and tuberculosis have a higher mortality in the low-income group.

This suggests that there is a penalty other than that imposed by the internal revenue service for higher incomes. It would be an interesting speculation as to just what makes the difference — whether over-nutrition, the stress that goes with success in business, a tendency to a faster rate of living generally, or a combination of factors. The interesting observation was made that the gap between incomes in these two groups of states has narrowed in proportion to the health gap. This is in accord with the Biblical prayer, "Give me neither poverty nor riches."

THE THREE R'S IN RUSSIA

The United States News and World Report for February 29 says that a group of United States school superintendents who recently visited Russia reported to a convention of school administrators in Atlantic City that Soviet schools are still using methods abandoned in the United States years ago. The children actually learn the alphabet and phonics before beginning to read. Many American parents are old-fashioned enough to think that the schools of this country took a long step backward when they abandoned the time-honored

method of first learning the alphabet and using the phonetic system in reading, and copied the Chinese system of using symbols for words instead of combinations of letters. As a result the poor Chinaman has to learn thousands of symbols instead of the 26 letters of our alphabet. It would be a safe bet that Russian children are better spellers than our American youngsters. They could hardly be worse.

Another observation: More and earlier written work is required of Russian children. This too seems to many parents a good thing.

The visitors finally reported on the third R: That in Russia emphasis is placed on formal arithmetic drills with more stress on rules than in this country. Might this not help explain the greater progress in science made by the Russians now causing us so much concern? It may be that the Russians can teach us something after all.

DEAN W. C. DAVISON RESIGNS AS DUKE MEDICAL SCHOOL DEAN

As all our readers know, Dr. W. C. Davison, who has been dean of the School of Medicine of Duke University since its beginning, has resigned as dean, effective July 1. He has well earned the right to rest from the exacting duties of the deanship, but it is hard to think of the Duke School of Medicine without "Dave" as its dean. Since its first class was admitted in 1930 he has met the demands of his office with so little apparent effort, and yet so efficiently, that the burden seemed lighter than it really was. He deserves great commendation for the fine work he has done: organizing and directing the first four-year medical school in North Carolina; organizing his own Department of Pediatrics; writing and keeping up to date by constantly revising the most popular reference work on pediatrics (The Compleat Pediatrician); and keeping in touch with the constantly increasing number of Duke graduates scattered all over the world.

It is good to know that he will continue to serve as the James B. Duke Professor of Pediatrics. This JOURNAL, on behalf of the North Carolina medical profession extends congratulations to Dr. Davison upon having given such notable leadership in medical education for the past 30 years,

and offers the hope that he will continue to serve for many more years as an elder medical statesman.

The choice of Dr. Barnes Woodhall, professor of neurosurgery, as his successor is a happy one. Many Duke alumni who have known Dr. Woodhall have expressed their gratification in his selection, and their confidence that he will continue to uphold the high standards set by Dr. Davison. It is hard to decide whether to extend Dr. Woodhall congratulations or sympathy, as he takes up his administrative duties. Perhaps it is proper to offer a measure of both.

THE LONG VIEW OF BLUE SHIELD

If you aren't too sure just what Blue Shield means to medicine—and to you and me—then try to imagine what the economics and the sociology of medical practice would be like without Blue Shield.

Remember first that most Blue Shield Plans were organized by local units of organized medicine 15 or 20 years ago. Medicine then faced an urgent popular demand for some mechanism through which people could prepay unpredictable medical costs. The insurance companies doubted that medical bills could be safely covered by insurance methods; and the politicians and social reformers were openly skeptical that doctors and patients would ever be able to get together voluntarily on any workable prepayment plan.

For the first time in modern history, America's physicians—aided and abetted by free labor, free industry and the genius of American free enterprise—solved a complex nation-wide social problem by voluntary action.

Blue Shield is the one prepayment plan exclusively devoted to the mutual interests of patient and doctor. It's "nonprofit"—which is to say that the profits belong to the subscriber, and they're immediately returned to him in terms of broader services covered and more adequate payments for his doctor's services when he needs them. Blue Shield serves all segments of the community, not just those favored elements who need it least and who offer the best prospect of profitable underwriting.

In most areas, the local physicians are voluntarily accepting Blue Shield payments in full payment of services required by subscribers in low or medium income brackets, recognizing that in Blue Shield—

and *only* in Blue Shield—the payment schedules reflect the profession's own evaluations of its services and procedures.

DR. TOM D. SPIES

Dr. Tom D. Spies, president-elect of Southern Medical Association, died February 28 at the New York Memorial Center for Cancer and Allied Diseases.

Dr. Spies was a pioneer worker in vitamin deficiencies. He first used nicotinic acid as a specific for pellagra. He won many awards for his outstanding work in nutrition. In 1939 the American College of Physicians selected him for the John Phillips Memorial Award for Achievement in Internal Medicine, In 1957 the American Medical Association gave him its . Distinguished Service Award. The Southern Medical Association in 1959 gave him the Seale Harris Medal for important research in the field of metabolism, endocrinology, and nutrition. Dr. Spies was to have been installed as the president of the Southern Medical Association at its fifty-fourth annual meeting in St. Louis October 31-November 3.

Dr. E. H. Lawson, of New Orleans, S.M.A. president, truly said that in his death the "whole world had lost a great humanitarian. His name will be enshrined with those of other great benefactors of their fellowmen."

BRIGHTER PROSPECTS FOR SENIOR CITIZENS

In his address published in this issue, Banker G. Warfield Hobbs, III, sounds the most optimistic note heard in many a day about the future of our Social Security. His reasoning is quite logical—that the present generation of older citizens is at the lowest financial ebb that this country is likely to experiene. He points out the reasons for this low ebb—that their earning power was not great enough to enable them to save for the future. It is to be hoped that with the increased earning power of the present young and middle-aged workers, they will have the foresight to save enough to keep them from want in their old age.

Mr. Hobbs' paper will bear careful reading—especially the last paragraph suggesting that we utilize our voluntary insurance plans instead of the Forand type of government assistance as a means of caring for our older people.

President's Message

THE CRISIS FACING AMERICAN MEDICINE

It is well that we hear again the following statement of the president of the American Medical Association, Dr. Louis M. Orr: "American medicine moves closer each day towards the most important crisis we have ever faced."

All of us know that he is talking about the "Forand Bill," that indirect scheme confronting us to bring about step by step in piecemeal style the socialization of American medicine.

Let there be no mistake about it, the crisis is real, the threat is positive, the battle lines have been drawn, and the opportunity of doctors to work in an atmosphere of freedom is at stake. We must attack with our plans if we are to preserve our free medical system. Time marches on and we must make the best use of it by proving to the legislative bodies that we, as a profession, do have already established sound programs through our sponsored Blue Cross and Blue Shield insurance programs and through the help and valiant support of the private insurance companies.

Our opponents can lose many times, returning after each defeat to the legislative halls with new plans for socialized schemes, but remember we can only lose once. Once a socialized measure is passed and established, its malignant growth will eventually spread to fetter our entire free enterprise system.

How the issue is resolved will depend upon the individual and collective effort of you and every physician in your county society, in our State Society, and in our nation. The degree to which we help rally community support for us and our way of the free choice of the practice of medicine is the important factor.

We should be familiar with all of the facts of the Forand Bill that is currently before the Ways and Means Committee of the House of Representatives in order that we might intelligently discuss and oppose its provisions. As physicians we must lead; therefore, if you have not done so this year

Read before the Public Relations Conference, Pinehurst, January 30, 1960,

in your county society, it is still not too late to do the following:

- 1. Familiarize your members with the Forand Bill and what it can do to downgrade the health care of the aged.
- 2. I plead with you to have each member write his congressman expressing his views and as a county society to send a resolution, a new one for this year, 1960. Only seven county societies have reported to Headquarters Office that they passed a resolution in 1959. I urge you to go home and as presidents, vice presidents, secretaries, or whatever officer you are, to do this immediately. By May let's be 100 per cent in having participated in this one way alone.
- 3. Now tell *your* story to other people. Forand and his cohorts are making speeches every day for what the passage of this bill will do for the old folks, but are you telling your patients, your golf, hunting, and fishing friends, the bankers, the industrialists, the civic clubs, and the butchers, bakers, and candlestick makers in your community what you and physicians like you all over this land are doing to provide better health care for the American people, particularly the aged?

A recent example of telling your story is that of Equitable Life Assurance Society of America. In a well directed letter every agent and employee of the Company was given the essential facts of the Forand Bill, its fallacies and the deleterious effect its passage would have upon private insurance carried by millions of resourceful individuals. Also support for our position is attested by the fact that 150 newspapers throughout the country already have printed editorials endorsing medicine's viewpoint. We must stimulate at all levels more of this type of action.

Being against the Forand Bill is not enough. We must continue our positive program and tell it and sell it to all people and solicit their support.

What have we done, you and I, in a positive way, as physicians in North Carolina.

We have a program, a very definite and effective program, in this state that is demonstrating from day to day how medical care can be financed without leading the patient to the brink of financial disaster. This is the Doctor's Plan and the Senior Certificate.

One hundred and thirty million Americans are covered with some form of health, accident, hospital, and professional insurance with either our own sponsored Blue Cross and Blue Shield programs or coverage with the vast commercial insurance companies. In a very definite sense we have an interest in all sound insurance plans, for they provide for the patient a way to prepay the cost of medical care, and we should make every effort to encourage our patients to carry adequate insurance. Keep them informed on up-to-date developments in the insurance field, particularly your "senior citizen" patients.

The plans and schedules of these insurance programs are flexible and have shown a remarkable ability to adjust to the changing demands placed upon them without bankrupting the Federal Government as the Forand Bill would do.

Private insurance, and particularly our own Doctor's Program, provides for us some degree of control and retains for the patient a free choice of the physician. Therefore it behooves all of us to lend our real support and just not lip service to our own Doctor's Program. Now is the time for you to help yourself in this crisis confronting you as a physician by becoming a participating member of the Doctor's Program and by encouraging other physicians to become members also. Remember we have in this program a positive plan of medical care to offer in our line of attack, and every physician should wisely consider becoming a participating member. We must see, however, that as members we use and not abuse Blue Cross and Blue Shield or permit the private groups to be exposed to unnecessary claims.

As you return to your homes pledge yourself to go back to your societies with enthusiasm.

Enthusiasm for and interest in your State Medical Society:

Enthusiasm for active participation in your county society in the various offices you hold.

Enthusiasm in telling your story to the community in which you live, enlisting the support of allies to help you.

Enthusiasm to support and strengther the Doctor's Program by becoming partic

ipating members.

Remember, enthusiasm pays the biggest dividends to be found in business or professional life, and enthusiasm and enlightment spell Success.

Working together and working hard, we can as physicians, and we must as physicians, preserve the free practice of American medicine. See that you as a physiciar and your county society assumes a role or real leadership in helping to do this.

John C. Reece, M.D.

Committees and Organizations

COMMITTEE ON VETERANS AFFAIRS

EDITOR'S NOTE: Veterans and their families are asking thousands of questions concerning the benefits their Government provides for them through Veterans Administration. Below are some representative queries. Additional information may be obtained at any VA office.

Q—I need some quick money for an emergency and have been wondering if I should cash in my permanent plan GI life insurance. Before I do this, I'd like some advice from VA. Will you please tell me what would be involved

A—The VA advises you NOT to cash in your permanent plan GI life insurance. All protection ceases when the policy is surrendered for cash, because, once cancelled, it cannot be restored. You would be much better off to borrow on your insurance. Paid up policyholders may borrow as much as 94 percent of the policy's cash surrender value.

Q—I know there's a deadline coming up pretty soon for us World War Two veterans on GI home loans. What is the date exactly, and what does it mean?

A—Under present law, July 25, 1960, is the cut-off date for World War Two veterans to apply for a GI loan. You will be allowed an additional year in which to have the loan processed and actually closed.

Q—I now receive VA disability pension, under the present law. If I decide to switch to the new system of payment, effective

July 1, 1960, will be change be considered final?

A—Yes. If you do decide to move over to the new system, you cannot go back to the old. If you have any doubt about which method of payment is more advantageous to you, the new or the old, ask your nearest VA office to help you decide.

Q—I am the beneficiary of my veteranhusband's GI insurance policy. He owed a few bills to private individuals at his death, which I intend to pay. Meanwhile, do these creditors have any right to seize the GI insurance policy to get their money right away?

A—No. The proceeds of your husband's GI insurance are exempted by law from any claims of private creditors. The insurance money may not be seized or attached to pay his debts.

CORRESPONDENCE

To the Editor:

The Bureau of Retirement and Insurance is receiving numerous queries from various sources asking whether the Civil Service Commission intends to request from Congress authority to delay the effective date of the Federal Employees Health Benefits program is the first day of the first pay period which starts in July 1960.

In response to one such query, the Chairman of the Commission has stated flatly that "there will be no request for the deferment of the effective date so far as the Civil Service Commission is concerned."

Andrew E. Ruddock, Director United States Civil Service Commission

Two Named to Staff of Pharmaceutical Manufacturers Association

Two appointments to the staff of the Pharmaceutical Manufacturers Association were announced recently by Austin Smith, M.D., PMA president. They are:

Dr. Robert J. Benford, former editor of the U.S. Armed Forces Medical Journal, of Washington, D.C. to be Director of Medical Relations for PMA; and

Mr. Milton Golin, former editor of the "Medicine at Work" section of the Journal of the American Medical Association, Chicago, to be Assistant to the President of PMA for special projects.

BULLETIN BOARD

COMING MEETINGS

Medical Society of the State of North Carolina, One Hundred Sixth Annual Session—Raleigh, May 8-11.

North Carolina Pediatric Society, in collaboration with the South Carolina and Virginia Pediatric Societies, Seminar Cruise to Bermuda—May 21-26.

Duke University, Fifth Medical Seminar Cruise—sailing from Wilmington, June 5, and from New York City, June 8; terminating in Hamburg, Germany, June 28.

Duke University Medical Postgraduate Course— Morehead-Biltmore Hotel, Morehead City, July 18-23

Second Annual Pre-Convention School Health Meeting, sponsored by the American Medical Association and the American School Health Association—Carillon Hotel, Miami Beach, Sunday evening, June 12.

American Medical Association, 1960 Annual Meeting—Miami Beach, Florida, June 13-18.

American Physician's Art Association, Twentythird Annual Exhibition-Miami Beach, June 18.

Symposium on Tuberculosis and Other Pulmonary Diseases, Saranac Lake, New York, July 11-15.
World Medical Association, Fourteenth Annual Assembly—West Berlin, Germany, September 15-22.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of March, 1960:

Dr. Milton Leonard Miller, Route 2, Chapel Hill; Dr. Morris Abraham Lipton, 1114 Williams Circle, Colonial Heights, Chapel Hill; Dr. Jacqueline Cato Hijmans Harris, 2907 Hope Valley Road, Durham; Dr. Thomas Chometon Gibson, Route 2, Chapel Hill; Dr. Herbert Aaron Saltzman, 2027 Bivins Street, Durham; Dr. Chauncey Goodrich Bly, 1103 Anderson St., Durham; Dr. A. Stark Wolkoff, Route 2, Knollwood Drive, Chapel Hill; Dr. Faith Newbury Ogden, 405 Coolidge St., Chapel Hill.

Dr. Wm. Benjamin Herring, Carolyn Drive, Albemarle; Dr. Claude Newton Ballenger, Jr., 143 N. 3rd St., Albemarle; Dr. Kenneth Hall Epple, 342 N. Elm St., Greensboro; Dr. Robert A. Gregg, Central Convalescent Hospital, Greensboro; Dr. T. Chalmers Vinson, Box 346, Laurel Hill; Dr. Xaver Franz Hertle, 504 Central Avenue, Butner; Dr. Paul L. Ogburn, Davis Hospital, Statesville; Dr. Arthur Kenneth Husband, 528 Fairmont Ave., Fairmont, West Virginia; Dr. Tolbert Lacy Stallings, 2404 White Oak Rd., Raleigh; Dr. Thomas G. Durham, 206 Cansler St., Kings Mountain.

Dr. Andrew Cleveland Miller, III, 213 W. Main St., Gastonia; Dr. John Alvin Kirkland, 1104

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He's a specialist—a career man in his chosen field. He has earned a good reputation *locally*, with efficient service and prompt attention to claims.

Moreover, he appreciates the impact that health insurance can have on the practice of medicine, and wants to co-operate with the local medical profession.

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Kenan St., Wilson; Dr. Franklin Jay Youngs, Wilson Clinic, Wilson; Dr. Allen Spencer, 3407 Reynolds Rd., Richmond 23, Virginia; Dr. James Richard Hughes, Snow Hill; Dr. Luther Sullivan Nelson, 121 W. Power Street, Ayden; Dr. Gene F. Koonce, 323 New Bridge St., Jacksonville.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. W. D. Huffines of the Department of Pathology, University of North Carolina School of Medicine, has been named a Markle Scholar in Medical Science. He is the eighth member of the U.N.C. faculty to be named for this honor. Dr. Huffines, a native of Reidsville, attended the Junior Order Home High School of Lexington and is a graduate of the U.N.C. School of Medicine. The other seven faculty members who have been named Markle Scholars are Drs. John B. Graham, George Penick, Isaac M. Taylor, Judson J. Van Wyk, T. Franklin Williams, Walter Hollander, Jr. and Robert Zeppa.

The fourth annual Parents' Day was held at the University of North Carolina School of Medicine on March 26, with some 360 persons from North Carolina attending. The club is made up of parents of students who are enrolled in the Medical School as well as parents of former and future students.

The University of North Carolina School of Medicine and the North Carolina Alcoholic Rehabilitation Program sponsored a Physician's Institute on Alcoholism at the Medical School on April 6,

Participants on the program included Drs. W. Reece Berryhill, John A. Ewing and George C. Ham, all of the U.N.C. School of Medicine; Dr. Thomas T. Jones of Duke and Watts Hospitals, Durham; Drs. N. L. Kelly and D. E. Macdonald, N. C. Alcoholic Rehabilitation Program, and Dr. Charles T. Wilkinson of Wake Forest, immediate past president of the North Carolina Academy of General Practice.

The Wyeth Fund for Postgraduate Education gave financial assistance for the institute.

A leave of absence for Dr. John H. Schwab of the Department of Bacteriology has been approved. He will spend the next academic year in London, where he will study under a National Institute, of Health Fellowship at the Lister Institute.

Dr. Erle E. Peacock Jr., of the Department of Surgery, participated in the Southeastern Surgical Congress held in New Orleans recently. He spoke on "The Use of Composite Tissue Homografts in the Restoration of Digital Flexor Tendon Injuries."

* * *

A seminar on "Care of the Severely Disabled Patient" was held at the North Carolina Memorial Hospital on April 14, under the sponsorship of the North Carolina Society for Crippled Children and Adults.

Among the participants in the program were Drs. William P. Richardson, and Donald Weir, of Chapel Hill, and Drs. Robert Gregg, Greensboro; Claude Nichols, Durham; and Robert Murphy, Hillsboro.

Objectives of the seminar were (1) the improvement and expansion of programs for the care and management of the severly disabled; (2) the determination of the needs of the physically handicapped individual and how to best serve him; (3) better communication between the agencies involved in patient care.

Dr. Robert A. Ross, chairman of the Department of Obstetrics and Gynecology and president of the Tri-State Medical Society, presided over the sixty-first annual meeting of the Association at Columbia, South Carolina, March 21-22.

Others taking part in the program included Dr. Luther Talbert and Dr. Samual F. Ravenel, of the U.N.C. School of Medicine and Dr. C. B. Fulghum, of the Dorothea Dix Hospital in Raleigh.

Dr. David R. Hawkins, associate professor, Department of Psychiatry, presented a paper on "A Multivariant Psychopharmacalogic Study in Normals" March 26-27 in Montreal, Canada, before the 1960 annual meeting of the American Psychosomatic Society. Assisting Dr. Hawkins in this research were Dr. Myron G. Sandifer, Jr., assitant clinical professor, Department of Psychiatry, Dr. Bernard Pasternack, assistant professor of biostatistics, and Robert Pace, M. A., research assistant in sociology and anthropology.

The day-long program of the Medical Alumni Association on March 9 was cut in half by a snow-storm. The meeting was adjourned following a noon business session.

New offlicers of the association elected at that time were Dr. Hugh McAllister, Lumberton, president elect; Dr. John Shaw, Fayetteville, vice president; Miss Sara Virginia Dunlap, Chapel Hill, secretary; and Dr. B. F. Barham of Asheboro and Dr. Haynes Baird of Charlotte, counsellors.

Speakers for the luncheon program were Dr. Kenneth B. Geddie, out-going president and Dr. W. Reece Berryhill, dean. The new president, Dr. John Rhodes of Raleigh, assumed offlice on this date.

The annual Phi Chi Medical Fraternity Lecture was held at the University of North Carolina School of Medicine Tuesday, March 8.

The guest speaker was Dr. Eugene A. Stead Jr. of the Duke School of Medicine, whose topic was "Hyper- and Hypoventilation."

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE

Dr. Wingate M. Johnson, professor emeritus of clinical internal medicine, is the editor of a book just released by Paul B. Hoeber, Inc. (Medical Division of Harper's) entitled "The Older Patient." The book is divided according to organs and body systems, and stresses the special problems involved in the management of the older patient. Most of the 2I doctors who have contributed chapters are members of the Bowman Gray faculty. They are Drs. Howard H. Bradshaw, David Cayer, D. LeRoy Crandell, Fred K. Garvey, Harold D. Green, James A. Harrill, Charles M. Howell, Lucile Hutaff, Wingate M. Johnson, Frank R. Lock, Martin G. Netsky, R. Winston Roberts, C. Glenn Sawyer, and Ernest H. Yount.

* * *

Dr. Eben Alexander, professor of neurosurgery, has been selected for a four year term as a member of the Board of Scientific Counselors of the National Institute of Neurological Diseases and Blindness, one of the eight intramural advisory boards of the National Institutes of Health. Members of the boards serve as consultants to the director of that Institute on intramural programs in matters of general policy.

Dr. Thomas B. Clarkson, assistant professor of experimental medicine, has been elected chairman of a new standing committee of the Association of American Medical Colleges. It is known as the Committee on Animal Care.

* * *

Dr. Richard Proctor, assistant professor of psychiatry, is the newly elected vice president of the Southeastern Psychiatric Society at the annual meeting of the Society in Southern Pines.

The Medical School has been awarded \$500,000 to support three professorships in basic medical sciences. They have been named the William Neal Reynolds Professorship of Anatomy, the Odus M. Mull Professorship of Biochemistry and the Gordon Gray Professorship of Physiology. Funds for the professorships were provided by Mrs. Anne Reynolds Tate and Mrs. Nathalie Gray Bernard.

This is the first step in the medical school's projected program of having at least one professorship for each of the school's thirteen departments.

0.00

In recent weeks the medical school has been visited by two professional groups—The Virginia Obstetrics-Gynecology Society Travel Club and the Brooklyn and Long Island Chapter of the American College of Surgeons.

Both groups participated in operative and dry clinics held by the faculty members of the Departments of Obstetrics-Gynecology and Surgery.

On April 1 eight students from the freshman class of 1960 were presented scholarships by the Z. Smith Reynolds Foundation. Four of the eight scholarships are valued at \$23,400 each and the remaining four—\$14,400 each.

Selection of the recipients is made from among North Carolina residents entering the freshman class on the basis of character, scholarship, potential as a physician and financial need. This is the third year the scholarships have been awarded.

* * *

Dr. Francis D. Moore, Chief Surgeon at the Peter Bent Brigham Hospital in Boston, Massachusetts, delivered the Nathalie Gray Bernard Lectures on April 25 and 26.

His topics were "Body Composition—Key to Our Understanding of Clinical Biochemistry" and "Clinical Shock in Man—An Evaluation of Current Research."

The Nathalie Gray Bernard Lectureship was established by the Bowman Gray faculty in 1942 in honor of Mrs. Bernard, one of the school's chief benefactors.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The second volume of a history of neurosurgery in World War II, co-edited by Duke University neurosurgeon Barnes Woodhall, has been published under the direction of the U.S. Army Surgeon General.

The book deals with injuries of the spine and peripheral nerves, which provided a heavier neurosurgical case load than did head injuries during the war.

An earlier volume, published in 1958, deals with administrative and clinical policies in war-time neurosurgery and with the injuries. Dr. Woodhall was co-editor of both the first and final volumes with Dr. R. Glen Spurling, professor of neurosurgery at the University of Louisville School of Medicine.

A foreword to the second volume by Major General S. B. Hays, the Army Surgeon General, states that "Neurosurgery furnished a particularly brilliant chapter of military medicine in World War II." He describes the program for paraplegics (patients who have lost the use of both upper limbs or lower limbs) as "an example of good medicine and of perceptive and compassionate care of men who otherwise would have been bedridden cripples all of their lives if, indeed, they had survived."

In addition to co-editing the book, Dr. Woodhall contributed four chapters and historical notes. The two-volume set is part of a series which forms the official history of the Army Medical Department in the second World War.

The Student American Medical Association held a regional meeting at Duke University, March 25-26.

The Student American Medical Association is composed of students in some 70 medical schools throughout the United States. Some 35 representatives of the 12 SAMA chapters that comprise Region I of the Association were present.

Special guests for the regional meeting at Duke included Bob Reed, assistant national executive director of the SAMA, Chicago; Tom Coleman, assistant director of the Association of American Medical Colleges, Chicago; and Jack London, medical sales director of the Minnesota Mutual Life Insurance Company.

Tom Ivey, Bowman Gray medical student and head of Region I, presided at the business sessions. Medical schools in Region I are Duke, the University of North Carolina, Bowman Gray, University of South Carolina, Bowman Gray, University of South Carolina, Emory University, University of Georgia, Medical College of Virginia, University of Virginia, University of Alabama, University of Puerto Rico, University of Florida and University of Miami.

NORTH CAROLINA HEART ASSOCIATION

The North Carolina Heart Association has set a deadline of May 15, 1960, for receiving applications for research grants-in-aid up to \$2,000 except in unusual circumstances when they will consider applications for larger amounts from investigators within the state working in the cardiovascular field. These grants-in-aid are awarded by the Heart Association and its chapters to scientists who need interim or supplementary financial support for on-going projects, or who wish to demonstrate by a pilot experiment the value of a new project.

Awarded three times a year, the grants-in-aid are one phase of the Heart Association's research program, which is supported by public contributions to the annual Heart Fund campaign.

Applications for these grants may be forwarded to Dr. Harold D. Green, Chairman, Research Committee, North Carolina Heart Association, Miller Hall, Chapel Hill, North Carolina.

This research program is separate from that of the American Heart Association, which annually makes numerous research grants to scientists in North Carolina. Those interested in inquiring about the national program are asked to write to the American Heart Association, 44 East 23rd Street, New York 10, New York.

SOUTHERN MEDICAL ASSOCIATION

The Section of Ophthalmology and Otolaryngology of the Southern Medical Association announces that papers are now being accepted by

physicians of either specialty living in the area of the Southern Medical Association for consideration for presentation at the next annual meeting to be held in St. Louis, Missouri, from October 31 to November 3, 1960.

The paper or an abstract of the paper may be sent directly to the Secretary, Dr. Albert C. Esposito, Suite 1212, First Huntington National Bank Building, Huntington, West Virginia as soon as possible.

AMERICAN PHYSICIANS ART ASSOCIATION

The twenty-third annual exhibition of art works by American physicians will be held June 13 through June 18, 1960, at the Miami Beach Exhibition Hall and Auditorium, according to an announcement by Lewis M. Johnson, M.D., president of the American Physicians Art Association.

Held in conjunction with the annual convention of the American Medical Association, the show will include more than 300 works of art in oil, water color, sculpture, crafts, photography and lithography.

Participants and prospective exhibitors may obtain further information from Dr. Kurt F. Falkson, 7 East 78th Street, New York City, Secretary of the American Physicians Art Association.

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AMERICAN MEDICAL ASSOCIATION

The practice of medicine in widely scattered regions of the United States will be the subject of a special hour-long documentary to be telecast over the NBC-TV network on Friday, May 27, at 8:30 p.m. (EST).

The program, to be telecast in color as well as black and white, is another in the award-winning "March of Medicine" series produced and sponsored by Smith Kline & French Laboratories in cooperation with the American Medical Association

Entitled "MD USA," the special report will depict the work of five American physicians in various geographical areas of the country as they provide care for a wide array of patients.

To uncover stories of the usual—and not so usual—work of American doctors, a special filming camera crew traveled thousands of miles by dogsled, swampboat and jet airliner.

"MD International," last year's "March of Medicine" entry, won the Peabody Award for its contributions to international understanding.

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, recently announced the resignation, effective April 15, of Dr. Bernard E. Conley as director of the Committee on Toxicology.

Dr. Conley, who joined the A.M.A. in September 1947, has accepted a position as medical research consultant to Hoffmann-La Roche, Inc. He will maintain offices in Chicago.

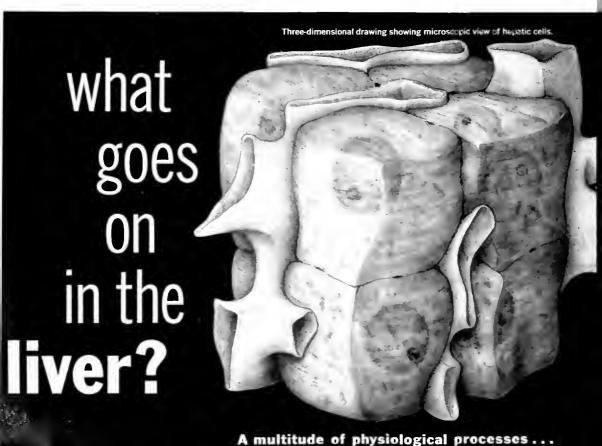
During his 12 years with the A.M.A., Dr. Conley helped to develop and influence the programs of the association's Committees on Toxicology and Pesticides. These programs received an award for outstanding public service from the National Safety Council and commendations from several other national organizations for achievements in the prevention of accidental poisoning.

Dr. Conley received his Ph.D. in pharmacology from the University of Chicago. Before coming to the A.M.A. he served as regional director of pharmacy service for the Veterans Administration in Ohio, Michigan, and Kentucky.

Dr. and Mrs. Conley and their four children reside at 1160 Sheridan Road, Lake Forest, Ill.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part 1, and requests for re-examination in Part 11 are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline for receipt of applications is August 1, 1960. No applications can be accepted after that date.



Candidates are requested to write to the office of the Secretary for a current Bulletin if they have not done so in order that they might be well informed as to the present requirements. Application fee (\$35.00), photographs, and lists of hospital admissions must accompany all applications.

As announced in the current Bulletin, "after July 7, 1962, this Board will require a minimum of three years of approved progressive Residency Training to fulfill the requirements for admission to examination. After the above date, training by Preceptorship will no longer be acceptable. Therefore the initiation of Preceptorships will not be approved after July 1, 1960."

Robert L. Faulkner, M.D. 2105 Adelbert Road Cleveland 6, Ohio

SYMPOSIUM ON TUBERCULOSIS AND OTHER PULMONARY DISEASES

The ninth annual Symposium for General Practioners on Tuberculosis and Other Pulmonary Diseases will be held in Saranac Lake, New York, July 11-15.

Since the management of the individual case of tuberculosis depends increasingly upon the family doctor, in cooperation with local health officers, it is important that he adjust, from time to time, his perspective to the ever-changing picture of the clinical and public health aspects of the disease. The Symposium at Saranac Lake provides the apportunity for such an adjustment by bringing the general practitioner in contact with a nucleus of physicians, surgeons, and others who have devoted most of their professional lives to the study of pulmonary diseases.

Inquiries regarding the Symposium should be addressed to the Registrar, Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases, P.O. Box 627, Saranac Lake, New York.

THIRD INTERNATIONAL CONGRESS OF PHYSICAL MEDICINE

The Third International Congress of Physical Medicine will be held August 21-26, 1960 inclusive, at The Mayflower, Washington, D. C.

The preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, a scientific film, etc. A copy of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

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Methischel acts to remove hepatic fat, stimulate regeneration of new functioning liver cells, and lessen tendency to filtersis and circlesis. Preliminary plans for the Third International Congress of Physical Medicine to be held in Washington, D.C., August 21-26 have been announced by Dr. Frank H. Krusen, congress president. Dr. Krusen is senior consultant and former head of physical medicine and rehabilitation at the Mayo Clinic, Rochester, Minnesota.

The program will be devoted to clinical, remedial, preventive, and educational aspects of physical medicine, and current methods employed in physical medicine and rehabilitation.

Previous congresses were in England in 1952 and in Denmark in 1956.

ANNUAL OTOLARYNGOLOGIC ASSEMBLY

The University of Illinois College of Medicine Department of Otolaryngology will offer an intensive postgraduate basic and clinical program for practicing otolaryngologists September 24-30. The Assembly is designed to bring to specialists a wide variety of current advances in management, therapy and philosophies. Review of basic morphologic features is also included by means of laboratory demonstrations, dissection and proprosection, all augmented by visual aids.

Interested physicians should write direct to the Department of Otolaryngology, University of Il-

linois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF THE AGED

Ray E. Brown, past president of the American Hospital Association, has been elected chairman of the Joint Council to Improve the Health Care of the Aged, it has been announced.

The Joint Council was formed in 1958 under the sponsorship of the American Dental Association, American Hospital Association, American Medical Association, and the American Nursing Home Association.

Mr. Brown, who is superintendent of the University of Chicago Clinics, was formerly administrator of the North Carolina Baptist Hospital, Winston-Salem.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The National Institutes of Health, the Public Health Service research center at Bethesda, Maryland, has reported that 564 research grants and 185 fellowships totaling \$11,344,183 were awarded during February 1960.

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DR. WEIR M. TUCKER

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VETERANS ADMINISTRATION

April, 1960

The Veterans Administration is strengthening its medical services for the aging and chronically ill, according to Administrator of Veterans Affairs Sumner G. Whittier.

Mr. Whittier said the VA is completing a comprehensive study of problems of aging veterans, and at the same time is going ahead with several newer related medical programs.

These include establishing day care centers for mental patients, improving vocational rehabilitation services, developing community home care plans for patients and planned living programs for VA domiciliary residents, and encouraging extension of volunteer services for follow-up purposes to VA patients after leaving the hospital.

In addition, three VA geriatric clinics have been established as pilot programs, and rehabilitation services are being extended from the clinics into the homes of service-connected veterans.

The Veterans Administration Hospital in San Juan, Puerto Rico, is making an unique contribution to a large scale VA medical research project.

The hospital is cooperating in a study of treatment for patients with esophageal varices, or varicose veins of the food pathway to the stomach.

This condition occurs when schistosomiasis closes the tiny blood vessels of the liver. The veins of the esophagus then become enlarged and, sometimes, fatal hemorrhage results.

The blood fluke, schistosoma, which causes schistosomiasis, is not found in the Continental United States although it is common in some other parts of the world. The disease is fast disappearing under the American flag since Puerto Rico is making major strides in controlling the snail that carries the parasite.

GRADUATE COURSE IN PROSTHETICS

New York University Post-Graduate Medical School will offer a series of two-week summer courses in prosthetics in cooperation with the International Society for the Welfare of Cripples just prior to the Eighth World Congress. These courses will constitute the third international prosthetics course sponsored by the Committee on Prosthesis, Braces and Technical Aids of the I.S.W.C.

Separate two-week courses for (1) physicians and surgeons; (2) therapists; and (3) prosthetists, will be offered each meeting from August 15 through 26, 1960.

Applications and further information concerning these courses may be obtained by writing: Dr. Sidney Fishman, Director, Prosthetics Education, New York University Post-Graduate Medical School, 342 East 26 Street, New York 10, New York.

WORLD MEDICAL ASSOCIATION

The German Medical Association (Bundesärzte-kammer) is extending a warm invitation to every doctor in the world to attend the fourteenth General Assembly of The World Medical Association and the sixty-third Deutsche Arztetag being convened in West Berlin, Germany September 15-22, 1960.

Doctors interested in receiving the latest details as to program, accommodations and registration are invited to address their requests to: Dr. Josef Stockhausen, Haedenkampstrasse 1, Köln-Lindenthal, Germany.

UNITED STATES CIVIL SERVICE COMMISSION

Milliman and Robertson, Inc., of Seattle. Washington, a recognized firm of consulting actuaries, has been retained by the Civil Service Commission to present a report following a study of the rates and benefit structures of the two Government-wide health benefit plans to he offered under the Federal Employees Health Benefits program scheduled to go into effect next July.

Purpose of the study will be to assure the Commission that the rates of the two plans, as finally approved, will "reasonably and equitably reflect the cost of the benefits provided" and will be "consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers," as required by the law which authorized the new program. The study will include detailed examination of both proposed plans and of the contracts offered to the Commission for approval. Among the items to be covered are amounts allocated for claims handling and other charges. The Commission emphasized that the action was taken in order to have the benefit of the independent judgment of a firm of national standing and reputation.

I think it's very unfortunate that we have put a magic implication on a date, for the indiscriminate retirement at 63, 65, 67, whatever date you like, the most popular one being 65, loses for us our most precious human asset, and that is wisdom. People are not born wise. Wisdom only comes with experience, and experience comes only with time. Rusk, H. W.: Stress in the Wrld: The Individual and the Doctor, Med. Ann. District of Columbia 27:259 (May) 1958.

The Month in Washington

Congress has been warned against acting on legislation to provide health care of the aged before receiving the recommendations of next year's White House Conference on Aging.

Representative Noah M. Mason (R., Ill.), ranking minority member of the House Ways and Means Committee which handles such legislation, put in the Congressional Record an exchange of correspondence with former Representative Robert W. Kean (R., N. J.), chairman of the National Advisory Committee supervising preparations for the White House Conference next January.

"Let us not waste the \$2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," Representative Mason said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Dr. F. J. L. Blasingame, executive vice president of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, Secretary of Health, Education and Welfare.

Dr. Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more comclusive and complete information" on a nationwide basis.

Dr. Blasingame and other AMA representatives emphasized to President Eisenhower's aides and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand bill, that would use the Social Security system to provide health care for the aged.

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

The National Association of Manufacturers charged in a pamphlet that sup-

porters of Forand-type legislation have exaggerated the health care needs of the nation's older people. The NAM pamphlet also said the Forand bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

Meantime, supporters of the Forand bill particularly the AFL-CIO, continued an intensive pressure campaign aimed at Congressional approval of the legislation in this national election year when Congressmen are more susceptible to such pressure

Another Democratic presidential hopeful, Senator Hubert H. Humphrey (D., Minn.), reiterated his support for Forand-type legislation. He proposed a six-point program for aid for the elderly, including "an extension of the Social Security system to cover the cost of hospital and nursing home care for senior citizens."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, has introduced similar, but even broader, legislation.

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions appeared in mid-March to be ready to support it with modifications.

The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill was pending, and the Senate would approve such legislation this session.

The issue of generic names vs. trade names in doctors' prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Dr. Austin Smith, president of the Pharmaceutical Manufacturers Association, testified at a Subcommittee hearing that "behind brand names lie the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side effects that might have

From the Washington Office of the American Medical Association, 1523 L Steet, N. W.

importance for a particular patient," Dr. Smith said.

Dr. R. B. Robins of Camden, Arkansas, who accompanied Smith at the hearing, submitted a similar statement. He said he used trade names because: "It is simpler to write such a prescription and I can be assured that no substitution will be made by the druggist—this assures me that the patient will get top quality."

Dr. Robins appeared before the Subcommittee as a private practicing physician and not in his capacity as a member of the

A.M.A. Board of Trustees.

Despite this testimony, Senator Estes Kefauver (D., Tenn.), the Chairman of the Subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

* * *

President Eisenhower's Conference on Occupational Safety urged stronger x-ray legislation by the states with an aim of protecting consumers and workers against too much radiation.

The three day Conference also said there is need "for effective educational programs to reduce both consumer and occupational exposures to x-rays used for diagnosis and therapy, x-ray installations in industry for product control and related purposes and various x-ray devices, such as shoe-fitting fluoroscopes."

The Conference also recommended intensive efforts to develop better ways of determining safe exposure levels of radiation.

Guide to SK&F Products Available

A handy reference guide to all Smith Kline & French products—including directions for treatment in the event of accidental overdosage—is now available for physicians' use in retail pharmacies throughout the United States.

The unique book, believed to be the first of its kind to release detailed overdosage information to pharmacists, contains extensive pharmacology and other technical data on every SK&F product.

Frazier Cheston, director of distribution for the Philadelphia pharmaceutical firm, urged physicians to contact their local retail pharmacists in emergencies when pertinent information on any SK&F product is needed.

BOOK REVIEWS

The Older Patient. By twenty-one authors, Edited by Wingate M. Johnson, M.D., Professor Emeritus of Clinical Medicine, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C. 589 pages. Price, \$14.50. New York: Paul B. Hoeber, Inc., 1960.

This book was intended primarily for the internist and general practitioner, but it contains much of interest to any doctor who deals with older patients, as well as to the oldsters themselves. The material contributed by twenty-one authors—most of them representing our state's three medical schools—has been so carefully edited that it was not possible to find any errors. Paul B. Hoeber, the publisher, has maintained the high standards which have won him and his father so much respect as publishers of medical books.

This reviewer, being an "older patient" himself, was particularly interested in the sections pertaining to his own ailments. Dr. Johnson's discussion of arthritis in the chapter on "The Musculoskeltal System" should be required reading for everyone over 40.

Dimness of vision and difficulties in hearing are the bane of most of us in the older age group, and these two subjects have been well covered. In his helpful and comprehensive chapter on "Mental Disorders of the Aging," Dr. E. W. Busse emphasizes the value of hearing aids and adequate glasses in minimizing the danger of paranoid tendencies, which are more common in deaf people and in those whose sight is failing than in those with normal hearing and vision. From personal experience, this reviewer can recommend a hearing aid as a means of relieving tension and frustration at committee meetings and conferences.

Other chapters deal with each of the systems of the body, emphasizing the diagnosis and treatment of disorders that are common in the latter half of life. In addition, there are chapters on anatomic changes, nutrition, the relief of pain, surgical principles, and infectious diseases, as well as a chapter on the sociologic aspects of aging. While it is difficult to select any one contribution as being more important than any other, Dr. Johnson's concluding chapter on "Helping the Older Patient Adjust to Age" deserves particular mention because of its timeliness. With increasing numbers of our population reaching the age of retirement, one of the physician's most important functions is to help his older patients make the necessary adjustments.

Because of the rising demand and need for information about the management of geriatric disorders, this book should find a place in the libraries of all physicians, both specialists and family doctors, whose practices include patients past 40.

The Reluctant Surgeon: A Biography of John Hunter, Medical Genius and Great Inquirer of Johnson's England. By John Kobler. 359 pages. Price \$4.50. New York: Donbleday and Company, 1960.

The man who "made surgery respectable" finds an adequate biographer in this volume by Mr. Kobler, a journalist who has previously written on scientific and medical topics. Interwoven with the biography of John Hunter is a more sketchy outline of his brother William's life and works, a highly necessary matter in view of their effect upon each other. There are also digressions on other interesting personalities of this age when fascinating people abounded in London. The attractions which the biography holds are in no small measure due to these vignettes.

Concerning John Hunter's life and work this biography seems accurate, sufficiently detailed, and surprisingly lacking in technical errors; for example only a curmudgeon would berate Mr. Kobler for confusing "glans" with "glands" (which may have been the printer's error). Mr. Kobler nicely evaluates John's contributions to biology and medicine, and amply illustrated them by references to Hunter's work from authorities modern and contemporary. There is a lack of the tendency to ascribe tenuously related modern developments to the subject of the biography which sometimes mars works of this type. The style is lucid and entertaining.

This biography can be recommended without qualification to anyone interested in the history of medicine, even superficially. It would make an excellent gift for a physician, and a suitable addition to general as well as medical libraries.

Ear, Nose and Throat Dysfunctions Due to Deficiencies and Imbalances. By Sam E. Roberts, M.D. 323 pages. Price, \$8.50. Springfield, Illinois: Charles C Thomas, 1957.

Every practicioner of medicine, whether general practitioner, otolaryngologist, obstetrician or dermatologist, has seen the patient who "doesn't feel well," who is tired, who has headaches. or who has "sinus trouble." it is probable that a large number of these patients have been considered to be neurotic or constitutionally inadequate or to be victims of "tension". On the other hand, many of these people are now recognized to be the victims of various forms of deficiencies and imbalances, particularly those of the autonomic nervous system and metabolism. The vascular-type headaches are generally felt to represent spastic phenomena, and the treatment of these frequently relatively disabling processes is directed toward restoration of normal function of the involved system.

In this monograph Dr. Roberts discusses many forms of dysfunctions and imbalances, together

with his own method of treatment which apparently has been evolved over many years experience. His many illustrative case reports are very convincing. Throughout the book he repeatedly pleads for a balanced diet, for the recognition ovarious imbalances, particularly gonadal imbalances, and for their treatment. Finally, he gives an outline of basic therapy in deficiencies and imbalances with five "musts" for the successful treatment of these dysfunctions.

This book is recommended reading, particularly for the otolaryngologist, but also for any physician because of its philosophic stimulus and the new ideas presented. Some of these ideas run counter to things which some of us have been taught in former years, but the man with a close mind is a poor physician.

Your Heart: A Handbook for Laymen. By H. M. Marvin, M.D. 335 pages. Price, \$4.50. Garden City, New York: Donbleday & Company, 1960.

Though heart disease kills more Americans every year than any other sickness, many people do not even know where their heart is located, as many attempted suicides have proved. This book, writter by H. M. Marvin, a past president of the Americar Heart Association, tells the layman how his heart works, how it can hreak down, and what to do if it does.

Beginning with a simplified explanation of the structure and functions of the heart, Dr. Marvir continues with a discussion of the various diseases that attack it—how they arise, how they are treated and how knowledge can provide a longer life. Drawing on the latest medical opinions and on the work of colleagues in the field, he reports fully on many controversial topics, including the possible influence of the diet as a cause of heart disease.

The Merck Index. Edition 7. 1,600 pages. Price, \$12.00. New York: Publications Department, Merck and Company. Inc., 1960.

The seventh edition of The Merck Index will be 400 pages larger than its predecessor and will contain several novel features, including a Russiar alphabet.

A unique encyclopedia of chemicals and drugs the Index has been published by the Merck organization for more than 65 years. It has become a standard reference work for chemists, pharmacists physicians, dentists, veterinarians, botanists, and members of allied professions.

The new edition contains nearly 10,000 descriptions of individual substances, more than 3,300 structural formulas, and about 30,000 names of chemicals and drugs alphabetically arranged and cross-indexed—10,000 more than its predecessor.

BOOK REVIEWS

Many of the additional substances admitted to the new Index play a role in biologic processes or are of therapeutic or technologic importance. The number of references to the medical and veterinarian uses of drugs is correspondingly expanded in the new edition. In addition to a larger number of structural formulas than contained in any previous issue, the current Index also provides empirical formulas, molecular weights, and percentage compositions.

An outstanding feature is a separate cross-index, arranged to enable the user to find any substance or compound, whether it is known to him by its systematical-chemical, generic, common, brand or trade name, and to guide him by page and number to the proper monograph.

Injuries of the Brain and Spinal Cord and Their Coverings. Edited by Samuel Brock, M.D. Price, \$18.50. New York: Springer Publishing Company, 1960.

With brain and spinal cord injuries still increasing, the need for a new edition of "Brock" (which has been out of print for several years) is greater than ever, particularly in the difficult area of medico-legal questions arising from these injuries.

The volume, edited by Samuel Brock, M.D., professor of neurology, New York University College of Medicine, and written by him and 30 other specialists, is a comprehensive work on the subject. Authoritative and conservative, it is used in the clinic and quoted in court.

As expert witness in many negligence cases for the past 20 years, the editor has become well known to the legal profession, respected for his ability to separate fact from fancy. The new edition of the book shows his hand throughout.

Classified Advertisements

WANTED: Male psychiatrist; Diplomate or with three years approved training; to join group practice 145-bed approved psychiatric hospital. Salary: \$15,000-\$18,000 first year; \$20,000-\$25,-000 second with incentive factor. Write Box 790 care this Journal, Raleigh, N. C.

DESIRABLE LOCATION for a physician, Contact Godley Realty Company, Mt. Holly Road, Charlotte, North Carolina.

PHARMACIST experienced in retail and hospital, desires to contact doctor(s) to establish clinic pharmacy. Replies kept strictly confidential. Box 790, Raleigh, N. C.

SITUATION WANTED: Anesthesiology Board eligible. American born: Class A graduate. Six years general practice experience prior to Anesthesiology residency. Available June 1, 1960. Box 790, North Carolina Medical Journal, Raleigh, North Carolina.

BOOKS RECEIVED

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The Reluctant Surgeon: A Bingraphy of John Hunter. By John Kobler. 359 pages. Price, \$4.95. Garden City, New York: 1960.

A Doctor Enjoys Sherlock Holmes. By Edward J. Van Liere. 141 pages. Price, \$3.00. New York: Vantage Press, 1959.

The Teen-Age Years: A Medical Guide for Young People and Their Parents. By Arthur Roth, M.D. 284 pages. Price, \$3.95. Garden City, New York: Doubleday & Company, 1960.

A Practical Guide to General Surgical Management. By Julian A. Sterling, M. D. 67 pages. Price, \$3.00. New York: Vantage Press, 1959

In Memoriam

Hubert Ashley Royster, M.D., November 19, 1871—November 7, 1959

After several years of failing health, North Carolina's most outstanding surgeon quietly passed away. The son of Dr. W. I. and Mary (Finch) Royster, he graduated from Wake Forest College in 1891, and from the University of Pennsylvania Medical School in 1894. After a year as resident physician at The Mercy Hospital at Pittsburgh, Pennsylvania, he returned to Raleigh and entered the practice of medicine with his father. His first interest, however, was surgery, and in 1906 he became the first man of North Carolina to limit his practice solely to that specialty. Ever the student, he made a record with the Board of Medical Examiners that is outstanding to this date. As ever the teacher, he was dean and professor of gynecology at the University of North Carolina's Medical Department, which was located in Raleigh from 1902 to 1910. Loyalty and respect for the dignity and integrity of his fellow physician made him take the position of professor of gynecology in deference to Dr. Agustus Knox, who was professor of surgery.

To list the honors bestowed upon him for his indefatigable efforts to raise the standards of the practice of medicine and surgery in his state and in the nation would need space to list all of the outstanding medical and surgical organizations in this country as well as intimate associations with the great men of surgery in our nation.

It suffices to say that for years he was a member of the editorial board of this JOURNAL; he served with distinction as secretary to the Board of Medical Examiners of North Carolina from 1914 to 1920, and as president of the State Association in 1922.

At the insistence of Secretary of the Navy Daniels in World War I, he kept his active practice in Raleigh, but made weekly trips to Washington as a medical member of the Advisory Committee of the Council of National Defense.

In 1901 he married the former Miss Louise Page of Maryland, and is survived by Dr. Hubert Ashley

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IN MEMORIAM

Royster, Jr., and Dr. Henry Page Royster, who carry on the Royster heritage in pediatrics and surgery, as well as a daughter, Mrs. Thomas Oxnard of Savannah, and eight grandchildren.

· Forced to retire from the active practice of surgery in 1939 because of a heart attack, he continued his ever present interest in teaching and writing, insisting always that character and truth are the most important things in life, and forever battling that the English language be spoken with accuracy.

In an editorial tribute by Jonathan Daniels, the very essence of this man was expressed: "He was a man sometimes outspoken in impatience with mediocrity. He had a ready scorn for men who did not maintain standards which he always honored in his profession and his life. He hated sloppy work and sloppy men, and his admiration for men of skill in his profession never surpassed his demand for character as a first essential in medical practice.

"... Age took the scapel from his hand sometime ago. Now death has removed him as a man honored among us. Still in hope and in the science of healing in North Carolina his life remains as an example for the future and a part of the best heritage of our past."

Alexander Webb, Jr., M.D.

Ransom D. Jones, M.D.

The endeavors of Dr. Ransom D. Jones in the field of Public Health and his service to the people of Lenoir and Jones Counties in this field will never be fully measured. Some of them have been of such a fundamental nature that their influence will be felt for decades yet to come. Others were rendered so unobtrusively and with so little thought of self credit that their real origin may never be known. During his long service as Health Officer for Lenoir and Jones Counties he labored usefully and well, despite physical handicaps and trying circumstances. He was dedicated to his job and loved it. He had the ability to get along with people. He loved his fellow man, and was considerate and understanding of his colleagues in the medical profession. He was loyal to his friends and kind and considerate of those who criticized or opposed him.

He dedicated his life to the performance of his work and the development of the health needs of the community in which he lived and labored. The members of the Lenoir-Greene-Jones Counties Medical Society respected and admired him. They looked upon him as an able and conscientious public servant, and for those of us who were privileged to share his friendship, we feel that we were better for having known him.

Lenoir-Greene-Jones Medical Society Moir S. Martin, M.D.

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WHEREAS our Heavenly Father has seen fit to call Home our beloved friend and co-worker Dr. Moir S. Martin, the North Carolina Board of Nurse Registration and Nursing Education, of which he was a member for 22 years, desires to record its deep sorrow at his passing on January 4, 1960. Therefore be it

Resolved, that the North Carolina Board of Nurse Registration and Nursing Education hereby gives formal expression of its grievous loss in this death and do note the passing from this life of our friend, who was esteemed by his associates, loved by his friends, respected by all, and was ever ready to advance the usefulness of the Boards by material contributions as well as by wise counsel and enthusiasm for the work.

Henry Hardy Simpson, M.D. 1897-1959

WHEREAS, our Creator, in His infinite wisdom, did give to this world, and particularly to the people of Alamance County, a good and humble physician; and

WHEREAS, our Maker, according to His will, yet not to our understanding, did see fit to remove from us our beloved colleague and friend, Dr. Henry Hardy Simpson; and

WHEREAS, as an outstanding and devoted physician, Dr. Henry Hardy Simpson did tirelessly and unselfishly minister to the needs of all people regardless of race, color, creed or financial status; and

WHEREAS, Dr. Henry Hardy Simpson gave willingly of his talents and means in support of the Civitan Club of which he was a member for ten years and did give substantially of his finances for improvements in the Altamahaw-Ossipee Community; and

WHEREAS, Dr. Henry Hardy Simpson donated generously to Wake Forest College, The University of Maryland, The Bowman Gray School of Medicine, numerous churches and charities, and gave of his time to serve the local school and various industrial organizations; and

WHEREAS, Dr. Henry Hardy Simpson did serve our county as coroner for four years; and

WHEREAS, to his family, to the many children and parents to whom he rendered devoted service, and to our entire community, the loss of Dr. Henry Hardy Simpson has brought great sorrow; and

WHEREAS, this community and this Medical Society will continue to miss the outstanding leadership and services of Dr. Henry Hardy Simpson; now, therefore, be it

Resolved that the Alamance-Caswell Medical Society hereby expresses its deepest appreciation and profound sense of loss in the passing of Dr. Henry Hardy Simpson on December 19, 1959; and be it further Resolved that a copy of this

resolution be published in the North Caro-LINA MEDICAL JOURNAL and a copy be placed in the minutes of the Alamance-Caswell Medical Society, and that a copy be sent Mrs. Simpson and to his three sons and daughter.

Dwight T. Kernodle, M.D. Vance Huffman, M.D. W. D. Rippy, M.D.

Frank C. Smith, M.D.

Dr. Frank C. Smith died February 25, 1960. He was born in Greenville, North Carolina, July 18, 1894. His father was a Methodist minister in Greenville at that time.

His elementary education was received in the public schools of several North Carolina cities where his father served various pastorates. His high school education was completed at Webb School for boys at Bell Buckle, Tennessee.

Following high school, he entered Trinity College, now Duke University, where he received his B. S. degree. After two years of medicine at the University of North Carolina he entered Jefferson Medical College of Pennsylvania, where he received his M. D. degree in 1921.

In 1924, he married Miss Margaret Monroe, who survives him with their two children, Frank C. Smith, Jr., and Mrs. W. D. Lawson, Jr.

After graduate study culminating in a residency at the Wills Eye Hospital, he entered the practice of ophthalmology in Durham, North Carolina, in association with Dr. B. W. Fassett. In 1927 he came to Charlotte to join the staff of the Charlotte Eye, Ear and Throat Hospital.

Dr. Smith's untiring efforts in the field of ophthalmology made him one of the outstanding men in this field in the Southeast. In earlier years he contributed frequently to the literature and awarded the Moore County Medal in 1931 for his paper read before the North Carolina State Medical Society.

Despite his very busy practice and a long and abiding interest in the Charlotte Eye, Ear and Throat Hospital, Dr. Smith was active in many other civic organizations. He served on the Board of the Y.M.C.A. for many years; on the Board of the Methodist Home for the Aged, where he was responsible for the landscaping of this very fine project. He was the founder of the Variety Eye Clinic for the care of the indigent. He was a longstanding, active member of the Rotary Club. His keen interest in forestry and soil conservation is manifest by several papers on this subject and membership on the Governor's Committee for Soi Conservation. He belonged to many professional organizations, serving with willingness and leadership in all of them.

WHEREAS the Mecklenburg County Medical Society and city at large will deeply miss the friendly counseling services of Dr. Frank C. Smith. be it

Resolved that the deepest sympathy be conveyed to the family of Dr. Smith.

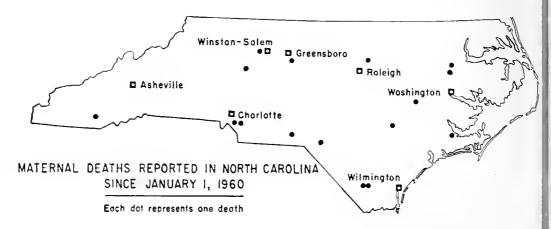
Mecklenburg County Medical Society

State College Professor Honored

Dr. Marvin L. Speck, professor of dairy bacteriology at North Carolina State College, was one of nine U.S. scientists honored by the Borden Company Foundation during the past year for outstanding research achievements.

A biographical sketch of Dr. Speck and a review of his accomplishments appear in the 1959 Borden Awards directory just released by the Foundation.

Dr. Speck was named for the Borden Award by the American Dairy Science Association. He was honored for his research in the field of nutrition of bacteria which has led to the development of a starter culture stimulant for improving cottage cheese manufacture.



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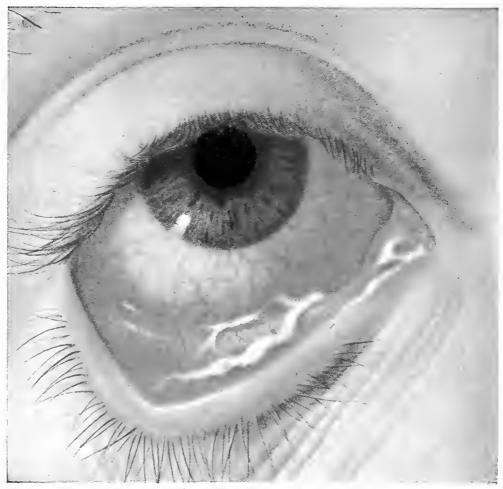
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1 Lippmann, O. Arch. Ophth. \$7,339, March 1957. 2 Gordon, D. W. Am. J. Ophth. \$6,740, November 1958, supplied. 0.5% Sterile. Ophthalmic Solution NEO: HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile. Ophthalmic Solution. HYDELTRASOL: In 5 cc. and 2.5 cc dropper valls. Also available as 0.25% Ophthalmic. Ointment. NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

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Manifestations for Allergie

TRISTAMINE is a unique combination of three antihistaminic agents, designed to afford high-level antihistaminic activity with a minimum of undesirable side-effects. The enhanced effectiveness achieved by the combination affords welcome relief from the discomfort of hay fever, seasonal and non-seasonal rhinitis, allergic dermatitis, urticaria and other conditions for which the contained antihistamines are clinically useful, while sedation and other side-effects commonly encountered with anti-

histamine therapy are minimized by the use of lower doses of the individual

drugs.

Tristamine is supplied in two convenient dosage forms-Tristamine Sustained Release Capsules, affording relief for periods up to ten hours, and Tristamine Elixir, a sugar free sorbitol type 'syrup' that will appeal to children and adults who prefer liquid medication.

CAUTION:

Federal law prohibits dispensing without prescription.

Contained Antihistamine	Dosage Range	Median Dose	20.0 mg. of	Percentage of Individual Median Dose
Phenyltoloxamine Citrate	25 mg.	25 mg.	6.25 mg.	25.0%
Pyrilamine Maleate	25-50 mg.	37.5 mg,	12.50 mg.	33.3%
Chlorpheniramine Maleate	2-4 mg.	3 mg.	1.25 mg.	41.7%
Percen Dose o histam	100.0%			



Sustained Release Capsules, 60 mg., Battles of 30, 100 and 1000.

Liquid, 10 mg./5 cc., Bottles of one pint and one gallon.

DOSAGE:

Tristamine Capsules 60 Mg. (Sustained Release) Adults, One capsule every twelve hours, morning and night or at breakfast and supper. In unusually resistant cases it may be desirable to give one capsule every eight

Tristamine Liquid (10 mg./5cc.)

Adults, two teaspoonfuls four times daily; Children 12 to 16, one to two teaspoonfuls three to 4 times daily; Children 6 to 12, One teaspoonful; Children under six, one-fourth to one-half teaspoonful.







Colitis? Gall Bladder Disease? Chronic Appendicitis?

Rheumatoid Arthritis? Regional Enteritis?

DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by $E.\ histolytica.$ In 15 of these subjects, nine stool specimens were required to establish the diagnosis.²

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.³

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat

suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal ameliasis.

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

1 -Cook, J.E., Briggs, G.W., and Hindley, F.W.; Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. $6(1821~({\rm Dec.}_3~1955)$

 Rinchart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Ludividuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., 54:708 (July, 1955).

3. Webster, B.H.: Amebiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat (9)897 (June, 1958).

*U S Pat. No. 2,864,745

THE S.E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

NEW YORK . KANSAS CITY . SAN FRANCISCO

Squibb Announces Chemipen Squibb Announces Chemipen Squibb Announces

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy

As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new .chemically improved oral penicillin, available for clinical use. With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec.19)1959.

reaches all nasal and paranasal membranes

 $systemically^1$

Pharmacologically balanced formula for prompt symptomatic relief

- · in nasal and paranasal congestion
- · in sinusitis and postnasal drip
- in allergic reactions of the upper respiratory tract

Triaminic^{2,3} is safer and more effective than topical medication

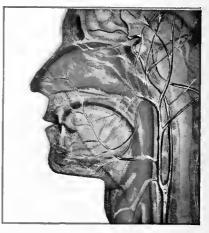
- transported systemically to all respiratory membranes
- · provides longer-lasting relief
- presents no problem of rebound congestion
- · avoids "nose drop addiction"

Relief is prompt and prolonged because of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core
disintegrates to give 3 to
4 more hours of relief



Dosage: 1 tablet in the morning, midafterooon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides: 1/2 the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides: 1/4 the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours): Adults - 1 or 2 tsp.; $Children\ 6\ to\ 12 - 1$ tsp.; $Children\ 1\ to\ 6 - \frac{1}{2}$ tsp.; $Children\ under\ 1 - \frac{1}{4}$ tsp.

Fabricant, N. D.: E.E.N.T. Monthly 37;460 (July) 1958.
 Lhotka, F. M.: Illinois M. J.: 112:259 (Dec.) 1957.
 Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

the leading oral nasal decongestant...

Triaminic^{*}

timed-release tablets and juvelets also non-alcoholic, fruit-flavored syrup

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Your patient will often respond promptly to Neocholan therapy. It greatly increases the flow of thin, nonviscid bile and corrects biliary stasis by flushing the biliary system. It also relaxes intestinal spasm, resulting in an unimpeded flow of bile and pancreatic juice into the small intestine. Neocholan helps to promote proper digestion and absorption of nutrients. It also encourages normal peristalsis by restoring intestinal tone.

Each tablet provides: Dehydrocholic Acid Compound, P-M Co. 255 mg. (Dehydrocholic Acid, 250 mg.); Homatropine methylbromide 1.2 mg.: Phenobarblat 8.0 mg. Supplied in bottles of 100 tablets.



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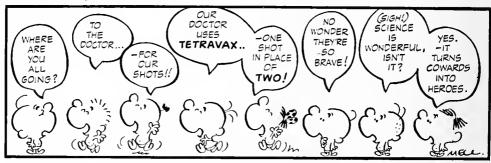
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Poliomyelitis-Diphtheria-Pertussis-Tetanus

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DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more diseases...with fewer injections

Dose: 1 cc.

Supplied: 9 cc. vials in clear plastic cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.



For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.



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Butazolidin°

brand of phenylbutazone

Ten years of experience in countless cases—more than 1700 published reports—have now established the eminence of Butazolidin among the potent non-hormonal antiarthritic agents.

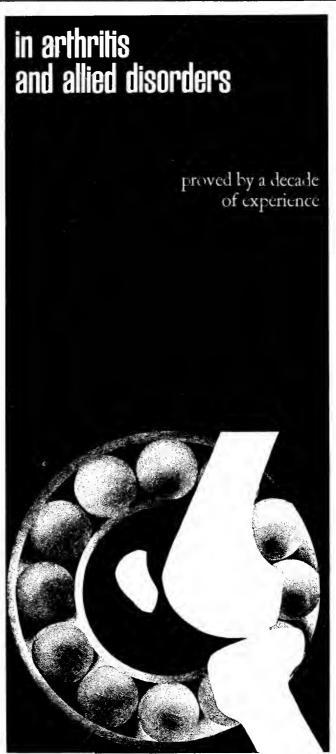
Repeatedly it has been demonstrated that Butazolidin: Within 24 to 72 hours produces striking relief of pain. Within 5 to 10 days affords a marked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over, months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

Butazolidin® brand of phenylbutazone: Red-coated tablets of 100 mg. Butazolidin® Alka: Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

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17.40



Lifts depression...as it calms anxiety!

For geriatric and chronically ill patients a smooth, balanced action that lifts depression as it calms anxiety...rapidly and safely

Balances the mood-no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient - they often aggravate anxiety and tension. And although amphetamine-barbiturate combinations may counteract excessive stimulation - they often deepen depression.

In contrast to such "seesaw" effects, Deprol lifts depression as it calms anxiety.

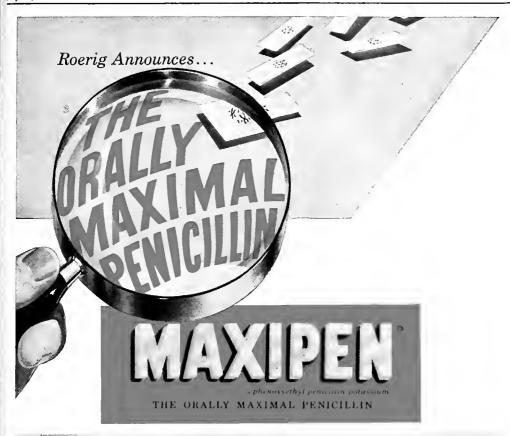
Acts swiftly—the patient often feels better, sleeps better, within two or three days. Unlike most other antidepressant drugs, Deprol relieves the patient quickly—often within two or three days.

Acts safely—no danger of hypotension or liver damage. Deprol does not cause hypotension, tachycardia, jitteriness, or liver toxicity. It can be safely administered with basic therapies.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be gradually increased up to 3 tablets q.i.d. Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCI) and 400 mg. meprobamate. Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

'Deprol'





Maximal Absorption Acid stable, highly soluble

Maximal Blood Levels

Maximal Flexibility

May be administered without regard to meals. However, highest absorption is achieved when taken just before or between meals.

Maximal Oral Indications

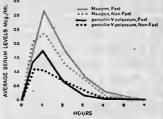
Indicated in infections caused by streptococci, pneumococci, susceptible staphylococci, and gonococci

DOSAGE: For moderately severe conditions, 125 to 250 mg, three times daily. For more severe conditions, 500 mg, as often as every four hours around the clock.

NOTE: To date, MAXIPEN has not shown less allergic reactions than older oral penicillins. Usual precautions regarding penicillin administration should be observed.

SUPPLIEO: MAXIPEN TABLETS, scored, 125 mg. (200,000 units), bottles of 36; 250 mg. (400,000 units), bottles of 24 and 100 tablets. MAXIPEN FOR ORAL SOLUTION; reconstituted each 5 cc. contains 125 mg. (200,000 units), in 60 cc. bottles.

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*Based on 3294 individual serum antibiotic determinations. Complete details available on request.

MAXIPEN, the orally maximal penicillin, is a triumph of man over molecule; $\boldsymbol{\alpha}$ product of Pfizer Research



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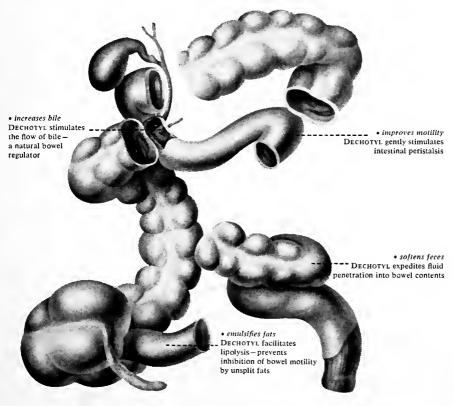
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IN THE NEW, CHERRY-FLAVORED

75 mg./5 cc. tsp., in 2 fl. oz. bottle-3-6 mg. per lb. daily in four divided doses

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helps free your patient from both... constipation and laxatives

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well tolerated...gentle transition to normal bowel function



Recommended to help convert the patient—naturally and gradually—to healthy bowel habits. Regimens of one week or more are suggested to assure maintenance of normal rhythm and to avoid the repetition of either laxative abuse or constipation.

Average adult dose: Two Trablets at bedtime as needed or as directed by a physician.

Action usually is gradual, and some patients may need 1 or 2 Trablets 3 or 4 times daily.

Contraindications: Biliary tract obstruction; acute hepatitis.

DECHOTYL TRABLETS provide 200 mg. DECHOLIN,® (dehydrocholic acid, AMES), 50 mg. desoxycholic acid, and 50 mg. dioctyl sodium sulfosuccinate, in each trapezoid-shaped, yellow Trablet. Bottles of 100.

*AMES T.M. for trapezoid-shaped tablet,

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-New England J. Med. 261:478, 1959 (Schiller, I. W. and Lowell, F. C.)

Dimetane works with an effectiveness of 91% in respiratory -NEW YORK J. MED. 59:3060, 1959 (Fuchs, A. M. and Maurer, M. L.). allergies In allergic and pruritic dermatoses the effectiveness rate of Dimetane is 94.6% -antibiotic med. a clin. Therapy 6:275, 1959 (Lubowe, 1.1.). The A. M. A. Council on Drugs characterizes Dimetane as demonstrating "...a high order of antihistaminic effectiveness and a low incidence of side effects."

for your next allergic patient R DIMETANE Extentabs⁸ (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIMETANE-TEN Injectable (10 mg./cc.) or new// DIMETANE-100 Injectable (100 mg./cc.).

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provides symptomatic relief of nasal congestion and rhinor-rhea of allergic or infectious

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'Actidil'® brand Triprolidine Hydrochloride 2.5 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride 60 mg. 30 mg.

safe and effective for patients of all ages suffering from respiratory tract congestion

	DOSAGE		
	TABLETS	SYRUP (5 cc. tsp.)	
Adults and older children	1	2	three
Children 4 months to 6 years of age	1/2	I	times
Infants through 3 months	_	1/2	daily









more and more physicians are prescribing this triple sulfa







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Squibb Triple Sulfas (Trisulfapyrimidinee)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

specificity for a wide range of organisms, superinfection rarely encountered. soluble in urine through entire physiologic pH range minimal disturbance of intestinal flora. excellent diffusion throughout tissues. readily crosses blood-brain barrier. sustained therapeutic blood levels. extremely low incidence of sensitization SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).



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Lanesta Gel, "...found to immobilize human spermatozoa in one-third to one-eighth the time required by five of the leading contraceptive products currently available . . ."* thus provides the extra margin of assurance in conception control. The accelerated action of Lanesta Gel – it kills sperm in minutes instead of hours – may well mean the difference between success and failure.

*Berberian, D. A., and Slighter, R. G.: J.A.M.A. 168:2257 (Dec. 27) 1958.

In Lanesta Gel 7-chloro-4-indanol, a new, effective, nonirritating, nonallergenic spermicide produces immediate immobilization of spermatozoa in dilution of up to 1:4,000. Spermicidal action is greatly accel-

erated by the addition of 10% NaCl in ionic form. Ricinoleic acid facilitates the rapid inactivation and immobilization of spermatozoa and sodium lauryl sulfate acts as a dispersing agent and spermicidal detergent.

Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can be certain that Lanesta Gel provides faster spermicidal action — plus essential diffusion

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a position where they can act upon the

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Supplied: Lanesta Exquiset . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

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A product of Lanteen® research.



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0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized, with an expiration date on each package.
Being Digitalis in its completeness, this preparation comprises the entire therapeutic value of the drug.

It provides the physician with a safe and effective means of digitalizing the cardiac patient and of maintaining the necessary saturation.

Security lies in prescribing the "original bottle of 35 pills, Davies, Rose."

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This nature-loving physician achieved immortality by falling out of a tree

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Glycamine is a New Chemical Compound – not a mixture of alkalis—that re-establishes normal digestion without affecting enzymatic activity.

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GLYCAMINE TABLETS AND LIQUID

Available in bottles of 100, 500 and 1000 tablets; or pints.

Low dosage prorides prompt long lasting relief

> • Only four pleasant tasting, chew-up tablets or four teaspoonfuls needed daily. Each dosage maintains optimum pH for 4½ hours.

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PHARMACEUTICALS

Greensboro, North Carolina

Tetracycline Phosphate Complex (TETREX®) in the Therapy of PNEUMONIA

Preferably, antibiotic therapy should be based on pretreatment culture of the offending pathogen, but in bacterial pneumonia the problem may well be too pressing to permit the required delay of 24 to 48 hours. A differential diagnosis among bacterial pneumonias, based on such clinical grounds as speed of onset, sepsis and pain may guide the choice of antibiotic for initiation of therapy.

Should clinical judgment dictate that antibiotic therapy be started immediately, at the same time a sputum sample or a subglottic swab can be sent to the laboratory for culture and sensitivity studies. If the response to the first antimicrobial agent proves unsatisfactory, a reasonable basis for changing therapy will then be at hand.

Choosing the Antibiotic

Since therapy must be started at once for bacterial pneumonia, it is advisable to choose a broad-spectrum antibiotic that quickly produces high levels of active agent (e.g., tetracycline phosphate complex, TETREX). Such an antibiotic probably has the best chance of controlling the pathogen, whether it be gram-negative or grampositive. And if the laboratory report shows that the invading organism is much less sensitive to tetracycline than to other agents, the patient can then be changed to an appropriate antibiotic. If the difference in sensitivity is slight, then the possibility of side effects, sensitization, and toxicity should be evaluated before changing therapy to another antibiotic.

The greatest number of bacterial pneumonias are caused by pneumococci, which respond very well to penicillin, tetracycline, and chloramphenicol. Also, these antibiotics are usually effective against the other gram-positive coccal pneumonias. But penicillin is ineffective against the viral pneumonias and the gram-negative Hemophilus influenzae and Klebsiello pneumonine. Although K. pneumoniae causes only about 1 to 2 per cent of pneumonia cases on the average,1 these are apt to be acute and fulminating (Friedländer's pneumonia), with a high mortality rate if not effectively treated. Since pneumococcal pneumonia may be difficult to distinguish clinically from Friedländer's, except hy gram-stained sputum smear, it may be wiser to start treatment with an agent also effective against Klebsiella.

Penicillin, however, in addition to having a limited spectrum, also causes many minor and some serious sensitivity reactions. In a recent survey² it was found that penicillin produced

severe skin reaction. But most important was the observation that anaphylactic shock, with a fatality rate of about 9 per cent, was the most frequent serious reaction. Such severe reactions are almost always associated with parenteral administration.

Tetracycline is also clinically effective in primary atypical pneumonia,³

The tetracyclines (e.g., TETREX) have the advantage of a broad range of antimicrobial activity and low toxicity. And in addition, the physician does not have to trouble himself or his patients with repeated blood studies when he prescribes TETREX. Minor reactions such as gastric upsets or mild skin rashes occur occasionally. The most serious side effects are staphylococcal and monilial overgrowth, but these are rare and can be adequately controlled.

No one would deny that appropriate antibiotic therapy has greatly reduced morbidity and saved many lives of patients with bacterial pneumonia. Nevertheless, general supportive measures in the care of patients remain important even today. Especially in the desperately ill patient, antibiotics are not considered as substitutes for the individual evaluation. clinical observation and judgment of the physician.

Some Micro-organisms Susceptible^a to Tetracycline (TETREX)^b

Streptococcus; Staphylococcus; Pneumococcus; Gonococcus; Meningococcus; C. diphtheriae; B. anthracis; E. coli; Protens; A. aerogenes; Ps. aeruginosa; K. pneumoniae; Shigella; Brucella; P. tularensis; H. influenzae; T. pallidum; Rickettsiae; Viruses of psittacosis and ornithosis, lymphogranuloma inguinale, primary atypical pneumonia; E. histolytica; D. granulomatosis.

a Some strains are not susceptible.

b Table adapted from Goodman, L. S., and Cilman, A.: The Pharmaceutical Basis of Therapeutics. 2nd edition, New York, The Macmillan Co., 1956, pp. 1322-1323.

References: I. Wood, W. E., Jr.: In: A Texthook of Medicine. Edited by Cerl, R. L., and Loeb, R. F., 9th edition, Philadelphia, W. B. Saunders Co., 1955, p. 145, 2. Welch, H.; Lewis, C. H.; Weinstein, H. L., and Boeckman, B. B.; Severe reactions to antionics. A nationwide survey. Authintet Med. & Clin. Ther. 4-800 (Dec.) 1957, 3. Keefer, C. S.; The choice of an anti-infective agent, In: Drugs of Choice, 1958-1959. Edited by Walter Modell, St. Louis, The C. V. Mosby Co., 1958, p. 135.

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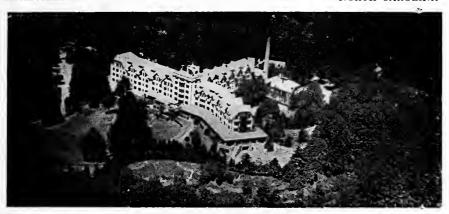
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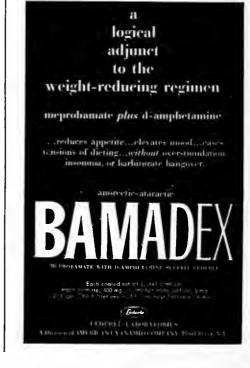
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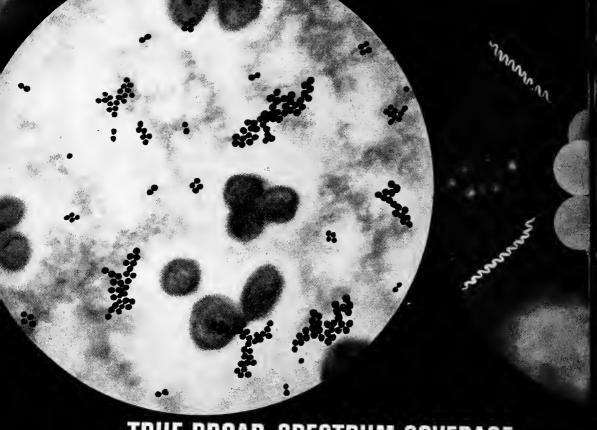
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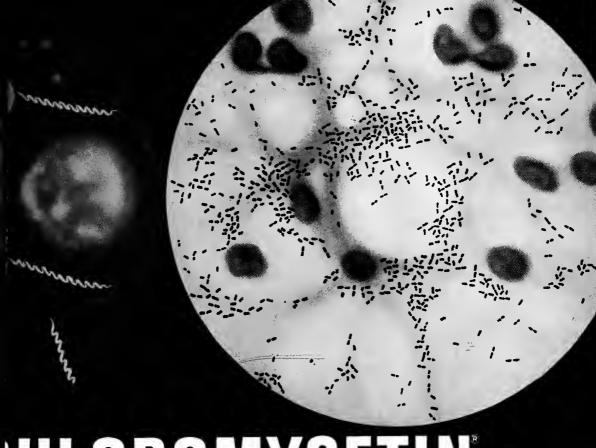
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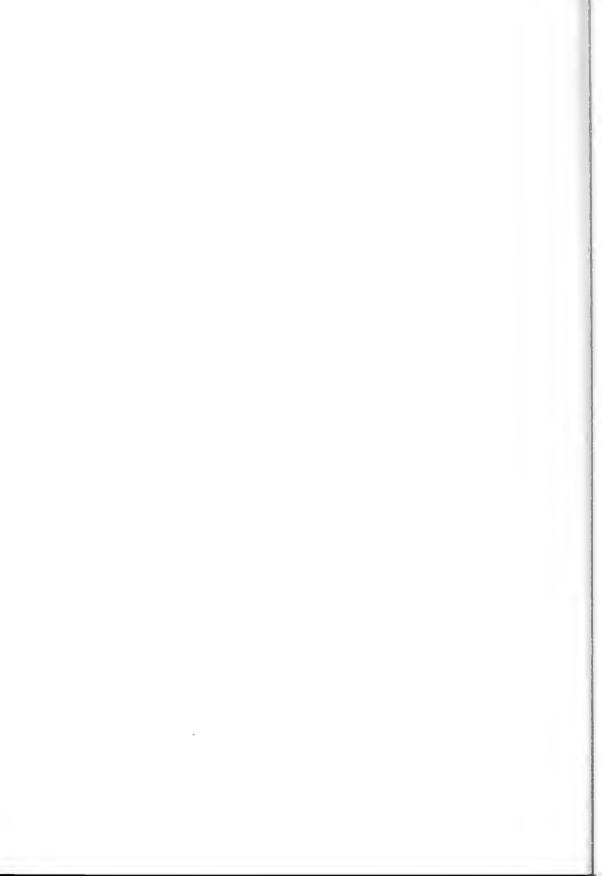
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5	1854	Rafeigh	37	J. H. Diekson	Myers, N. J. Pittman. N. J. Pittman, J. B. G. Myers, J. Graham	W. W. Harris	Daniel Dupree	80	14
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25	1878	Goldsboro	79	R ! Payne	E. M. Rountree, Richard Anderson, S. R.	James McKee	A. G. Carr	177	1
26	1879	Greensboro	109	Chas Doffy, Jr	Flowers, L. A. Stath. J. A. Gibson, Willis Alston, James McKee.	I J Prent	A. G. Carr	194	6
27	1880	Wilmington	105	l Γ Shaffner	A. A. Hill J. K. Hall, W. C. McDuffie, W. R. Wilson	I. J. Picot	A G- Carr	198	6
28	1881	Asheville	92	R B Haywood	R. F. Lewis. J. E. McRee, W. H. Lilly, R. H. Speight,	L. J Pirot	A. G. Carr	225	6
20	1882	Concord	65	Thes F Wood	W. J. H. Bellamy. T. J. Moore, D. J. Caio, S. E. Evans, John	I. J. Picot.	A. G. Carr	254	6
30	1883	Tarboro	112	J K Hall	A. W Krox J. M Hadley E S Foster		A G Carr	297	7
31	1884	Raleigh	112	A B. Pierce,	F. W. Potter G. W. Graham R. Dillard	L. J. Pirot.		310	7
3.5	1885	Durham	173	Т С МсОн⊞е	G. W. Long. James Mckee, T. E. Anderson, W. H.	L. J. Picot	1	348	7
		'	,	,	Whitehead A G Carr	M. C. Humbhr	R L. Payne Je	424	r.

SUPPLEMENT — TRANSACTIONS, 1959

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF "NORTH CAROLINA FROM 1849 TO 1959—Continued *Missing Data Not to be Found in Record

4				-Missing Data Not to be Found in Re					
no ste	Place of Meeting	Number in Attendance	President	Vice Presidents	Secretary	Treasurer	Members on Roll July 15	Honorary Members	Honorary Fellows
1886	New Bern	113	Joseph Graham	H. T. Bahnson, L. J. Picot, J. L. McMillan,	J. M. Baker	R. L. Payne, Jr	438	7	
1887	Charlotte	112	H T. Bahnsoo	W. W. Faison G. G. Smith, J. L. Nicholson, C. M. Van Poole, H. B. Ferguson	J. M. Baker	R. L. Payne, Jr	452		
1888	Fayetteville	133	T. D. Haigh	W. T Engett, J. A. Duan, T. E. Anderson	J. M. Baker	C. M. Van Poole	306	6	
1889	Elizabeth City	50	W. T. Ennett	W. J. Jones, S. W. Stevenson, G. W. Long	J. M. Baker.	C. M. Van Poole	410	6	
1890	Oxford	160	G. G. Thomas	R. L. Payne, Jr., Richard Dillard, S. D. Booth	J. M. Hays	C. M. Van Poole	414	6	
1891	Asheville	135	R. H. Lewis	S. W. Battle, J. L. Nicholson, W H. Lilly	J. M. Hays	C. M. Van Poole	422	ß	
1892	Wilmington	162	W. T. Cheatham	T. S. Burback, J. W. Long, W. H. H. Cobb, W. D. Hilliard	J. M. Hays	C. M. Van Poole	431	6	1
1893	Raleigh	221	J. W. McNeill	W. C. Galloway, H. H. Harris, J. M. Had-	R. D. Jewett	M. P. Perry	447	5	3
1894	Greensboro	166	W. H. H. Cobb	ley. Thomas Hill J. A. Hodges, R. W. Tate, Willis Alston, M. H. Fletcher	R. D. Jewett	M. P. Perry	454	5	3
1895	Goldsboro		J. H. Tucker	I Howell Way W H Harrell O McMul-	R. D. Jewett	M. P. Perry	436	7	3
1896	Winston-Salem	158	R. L. Payne	lan, C. A. Misenheimer. S. D. Booth, J. P. Munroe, J. A. Burroughe, J. E. Grimsley	R. D. Jewett	M. P. Perry	452	7	3
1897	Morchead City	103	P. L. Murphy	J. C. Walton, A. A. Kent, M. R. Adams, B. L. Long	R. D. Jewett	M. P. Perry	406	6	3
1898	Charlotte	•	rancis Duffy	E. C. Register, A. T. Cotton, J. H. B. Knight, F. H. Russell	R. D. Jewett.	M. P Perry	437	8	21
1899	Asheville	152	L. J. Picot	 W. Faison, J. W. White, H. H. Dodson, W. C. Brownson 	Geo, W. Presley	G T. Sikes	489	6	16
1900	Tarboro	115	George W. Long	C. M. Van Poole, James M. Parrott.	Geo. W. Presley	G. T. Sikes	482	6	21
1901	Durham	186	Juliao M. Baker	T. B. Williams, W. D. Hilliard. M. H. Fletcher, C. A. Julian, D. A. Stantoo, E. M. Summerell.	Geo. W. Presley	G. T. Sikes	515	5	18
1902	Wilmington	147	Robert S. Young	A. G. Carr, E. D. Dixon-Carroll, I. M. Tay- lor, J. M. Psrrott	Geo. W. Presley	G. T. Sikes	546	5	20
1903	Hot Springs	155	A. W. Knox	E. G. Moore C. A. Julian, W. W. Mc- Kenzic, J. L. Nicholson	J. Howell Way	G. T. Sikes	530	6	19
1904	Raleigh	326	H. B. Weaver	John Hey Williams, John C. Rodman, S. F. Pfohl	J. Howell Way	G. T. Sikes	1.033	8	17
1905	Greensboro	361	David T. Tayloe	C. A. Julian, John T. Burrus, I. W. Faison	J. Howell Way	G. T. Sikes	1,175	8	17
1906	Charlotte	406	E. C. Register	L. B. McBrayer W. H. Cobb, Jr., W. O. Spencer	J. Howell Way	G. T Sikes	1.234	8	16
1967	Morehead City	217	Samuel D. Booth	C. M Strong, J. E. McLaughlin, W. F. Hargrove	David A. Stanton	H. McK. Tucker	888	7 7	16
1908	Winston-Salem	372	J. Howell Way	J. E. Stokes, J. A. Turner, W. H. Dixoo	David A. Stanton	H. McK. Tucker	998	7	28
1909	Asheville	337	J. F. Highsmith	C. M. Van Poole, D. A. Garrison, D. O. Dees	David A. Stanton	H. McK. Tucker	1,067	7	25 35
1910	Wrightsville Beach	276	J. A. Burroughst E. J. Wood	E. J. Wood, John Q. Myers, L. D. Wharton	David A Stanton	H. D. Walker	1.080	8	35
1911	Charlotte	412	C. M. Van Poole	J. V. McGougan, W. E. Warren, L. N. Glenn	David A. Stanton	H. D. Walker	880	8	45
1912	Henderson ville	296	A. A. Kent	J. P. Monroe, W. P. Horton, J. G. Musphy	David A. Stanton	H. D Walker	950	8	44
1913	Morehead City	232	J. P. Munroe	F. R. Harris, E. S. Bullock, L. B. Morse.	John A. Ferreil	H D. Walker	1,133	8	40
1914	Raleigh	431	J. M. Parrott	E. T. Dickinson, J. T. J. Battle, D. E. Sevier	John A. Ferrell	H. D. Walker	1,228	8	47
1915	Greensboro	443	L. B. McBrayer	J. J. Phillips, C. W. Moseley, S. M. Crow- ell.	John A. Ferrell	H. D. Walker	1,221	9	68
1916	Durham	406	M. H. Fletcher	J. L. Nicholson, L. N. Gleco, W. H. Hardi-	Benj. K. Hays	W. M. Jones	1,228	10	79
1917	Asheville	280	Charles O'H. Laughinghouse	D. J. Hill, J. L. Spruill, J. H. Shuford.	Веој. К Наув	W. M. Jones	1,271	11	81
1918	Pinehurst	291	I, W. Faison	Wm. deB. MacNider Jos B. Greene, Ben F. Royal	Benj. K. Hays	W. M. Jnnes	1,087	11	81
1919	Pioehurst	335	Cyrus Thompson	J. W. Halford, T. W. Davis, A. McN.	SecTreas. Benj K Hays	Acting SecTreas L. B McBrayer	1,305	11	100
1920	Charlotte	479	C. V. Reycolds	Blair H. D. Walker, F. Stanley Whitaker Thos.	Benj. K. Hays	L. B. McBrayer	1,497	12	100
1921	Pinehurst	404	T. E. Anderson	C. S. Lawrence, W. H. Ward, J. M. Man-	Beoj. K. Haya	L. B. McBrayer	1,491	12	93
				olog	Deal. II. Maya	SecTreas.	1.,		
1922	Wieston-Salem	507	H. A. Royster	W. T. Parrott, B. C. Nalle, J. R. Mc- Cracken		L. B. McBrayer	1,871	12	100
1923	Asheville	356	J. W. Long	F. M. Hanes, T. C. Johnson, B. L. Long		L. B. McBrayer	1,592	9	101
1924	Raleigh	525	J. V. McGougan	J. L. Spruill, Eugene B Glena, D. A. Garrison		L. B. McBrayer	1,604	9	106
1925	Pioehurst	550	Albert Anderson	W. L. Dung, A. E. Bell, K. G. Averitt		I., B. McBrayer	1,657	10	116
1926	Wrightsville Beach	445	Wm. deB. MacNider.	J. P. Matheson. W. W. Dawson, H. H. Bass.		L. B. McBrayer	1,663	10	107
1927	Durham	653	John Q. Myers	J. W. Carroll, A. Y. Linville, C. H. Cocke.		L. B. McBrayer	1,691	10	121
1928		611	John T. Burrus	G. H. Macon, R. F. Leinbach, W. R. Griffin		L. B McBrayer	1,738	11	143
1929		671	Thurmao D. Kitchio.	W. L. Duon, Asheville, D. T. Tayloe, Jr., Washington, W. D. James, Hamlet		L. B. McBrayer	1	11	146
1930	Pinehurst	701	L. A. Crowell	W. B. Murphy, Wm. E. Warren, N. B.		I B McBraver	1.711	111	155
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NORTH CAROLINA MEDICAL JOURNAL

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1959—Continued

ı	Date	Place of Meeting	Number 10 Attendance	President	President-Elect	Vice Presidents	SecTreas.	Members on Roll July 15	Honorery Members
78	1931	Durham	714	J. G. Murphy	M. L. Stevens	C. A. Julian, Greensboro			
79	1932	Winston-Salem	740	M. L. Stevens	Jno B. Wright		L. B. McBrayer		10
80	1933	Raleigh	714	Jno B. Wright	1. H. Manning	J. R. McCracken, Waynesville		1,559	10 10
51	1934	Pineharst	728	I. H. Manning	P. P. McCain.	W. G. Suiter, Weldon			
82	1935	Pinehurst.	706	P. P. McCain	Paul H Ringer	J. F. McKay, Buie's Creek	L. B. MeBrayer		10
83	1936	Asheville	583	Paul H Ringer	C. F. Strosnider	J. K. Pepper, Winston-Salem	L. B. McBrayer		10
84	1937	Winston-Salem	767	C. F. Strosnider	Wingate M. Johnson		L. B. McBrayer		10
8.5	1938	Pinehurst	532	Wingate M. Johnson.	J. Buren Sidbury	Jno. F. Brownsberger, Fletcher R. B. McKnight, Charlotte	L. B. McBrayer	1,503	7
86	1939	Cruise to Bermuda.	319	J. Buren Sidbury	William Allan	J. F. Abel, Waynesville C. B. Williams, Elizabeth City	T. W. M. Long.	1.715	7
87	1940	Pinehurst	835	William Allan	Hubert B. Haywood	M. D. Hill, Raleigh F Webb Griffith, Asheville	T. W. M. Long	1,605	8
86	1941	Pineburst	755	Hubert B. Haywood.	F. Webb Griffith		T. W. M. Long T. W. M. Long (1)	1,661	7
89	1942	Charlotte	710	F. Webb Griffith	Donnel B. Cobh	T. C. Kerns, Durham Thos. Del. Sparrow, Charlotte	I. H. Manning	1,700	7
90	1943	Raleigh	736	Donnell B. Cohb	James W. Vernon	T. L. Carter Gatesville	Roscoe D. McMillan	1,837	8
91	1944	Pinehurst	760	James W. Vernon	Paul F. Whitaker	Julian Moore Asheville	Roscoe D McMillan	1,919	8
	1945	No meeting because				George L. Carrington, Burlington	Rescoe D. McMillan	1,982	8
		of O.D.T. restrictions		i	Oren Moore	Zack D. Owens, Elizabeth City	oscoe D. McMillan	1,811	7
92	1946	Pineburst	159			Wm. H. Smith Goldsbore; Zack D. Owens Elizabeth City		1,939	6
93	1947	Virg nis Beach, Vs	444	Wm M. Coppridge	Frank A. Sharpe	G E. Bell Wilson J B. Bullitt, Chapel Hill		2.191	7
94	1948	Pineburst	920	Frank A Sharpe (2)_	James F. Robertson	V. K. Hart, Charlotte J. G. Raby, Tarboro.	Roscoe D. McMillan	,	8
95	1949	Pinehurst	998	James F. Robertson.	G. Westbrook Murphy	Joseph J. Combs, Raleigh Joseph A. Elliott, Charlotte	Roscoe D. McMillan		5
96	1950	Pineburst	947	G Westbrook Murphy	Roscoe D. McMillan	Ben t. Royal Joseph A. Elliott	Millard D. Hill		5
97	1951	Pinehurst	935	Roscoe D. McMillan	Frederic C. Hubbard	Joseph A Elliott Henderson Irwin	Millard D. Hill		5
98	1952	Pineharst	969	Frederic C. Hubbard.	J. Street Brewer	Forest M. Houser Arthur Daughtridge	Millard D. Hill.		5
èè	1953	Pinehurst	1016	J. Street Brewer	Joseph A. Elliott	George W. Paschal John R. Bender	Millard D. Hill		5
100	1954	Pinehurst	1077	Joseph A. Elliott	Zack D. Owens	John F. Foster Julian A. Moore	Millard D Hill		6
101	1955	Pinehurst	991	Zack D. Owens	J. P. Rousseau	George W. Paschal, Jr. Elias S. Faison			
102	1956	Pinehurst	1022	James P. Rousseau.	Donald B. Koonce	E. W. Schoenheit Milton S. Clark	Millard D. Hill.		6
103	1957	Asheville	867	Donald B. Koonce	Edward W. Schoenheit	John S. Rhodes O. Norris Smith	Millard D. Hill		
104	1958	Asheville	751	Edw. W. Schoenheit.	Lenox D. Baker	George W. Holmes			8
105	1959	Asheville	651	Lenux D. Baker	John C. Reece	Amos N. Johnson Amos N. Johnson Kenneth B. Geddie			9
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TDied during his term of office; succeeded by E. J. Wood, first vice president. Died during term of office. (1) Died during term of office; succeeded by L. H. Mannin (2) Died during term of office; succeeded by James P. Robertson, president-elect.

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(1) See Irsquil-Alexander, (2) See Wilkes-Alicghany. (3) See Wittuur. Ashe and Ashe-Wattauga. (4) See Mitchell-Avery. (5) See Irsquil-Area and Ashe-Wattauga. (4) See Macui-Ciny. (8) See Irsquil-Stee Macui-Ciny. (8) See Irsquil-Stee March-Wattauga. (9) See Rowan-Davie. (10) See Davies Sant. (11) See March-Wattauga. (12) See March-Wattauga. (13) See March-Wattauga. (14) See Mitchell. (15) See Mitchell. (16) See Mitchell. (17) See Mitchell. (18) See Mitchell. (18) See Mitchell. (19) See Mitchell. (20) See Martin. (20) See Mathigton-Tyrrell and Martin-Wahlington-Tyrrell. (21) See Mitchell-Wattauga.

ROSTER OF MEMBERS OF NORTH CAROLINA STATE BOARD OF HEALTH FROM ORGANIZATION IN 1877 TO 1961

<u> </u>					
Name	Address	Appointed by		erm	
S. S. Satchwell, M.D., President	Rocky Point	State Society	1877		
Thomas F Wood MD Secretary	Wilmington	State Society	1877		
Joseph Graham, M.D.	Charlotte	State Society	1877	to	1878
Charles Duffer In M.D.	New Bern	State Society	1877	to	1878
Charles Dully, Jr., M.D.	Poloigh	State Society	1877		
Joseph Graham, M.D. Charles Duffy, Jr., M.D. Peter E. Hines, M.D. George A. Foote, M.D. S. S. Satchwell, M.D., President Thomas F. Wood, M.D., Secretary Charles J. O'Hagan, M.D., President George A. Foote, M.D. Marcellus Whitehead, M.D. H. C. Woodfin, M.D. H. G. Woodfin, M.D. A. R. Ledeux, Chemist William Cain, Civil Engineer	raieigii	State Society	1877		
George A. Foote, M.D.	warrenton	State Society	1878		
S. S. Satchwell, M.D., President	Rocky Point	State Society	1010	LO	1004
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1878	to	1884
Charles J. O'Hagan, M.D., President	Greenville	State Society	1878		
George A Foote M.D.	Warrenton	State Society	1878		
Morgollus Whitehead MD	Salisbury	State Society	1878	to	1880
Marcenus Wintercau, M.D.	Lovington	State Society	1878		
R. L. Paylie, W.D.	Uno nielin	Cou 7 P Vonce	1878		
H. G. Woodin, M.D.	CTANKIII	Gov. Z. B. Valice	1878		
A. R. Ledeux, Chemist	Chapel Hill	Gov. Z. B. vance			
William Cain, Civil Engineer	Charlotte	Gov. Z. B. Vance	1878		
R. L. Payne, M.D. M. Whitehead, M.D., President	Lexington	State Society	1881		
M Whitehead, M.D., President	Salisbury	State Society	1881		
W. G. Simmons, Chemist	Franklin	Gov. T. J. Jarvis	1881		
William Coin Civil Engineer	Charlotte	Gov T J Jarvis	1881	to	1883
William Cam, Civil Bigineer	Woke Forest	Gov T I Jarvis	1881	to	1883
W. G. Simmons, Chemist	(Value Forest	State Conjety	1883		
LI W Jones M D President	iwake rurest	istate society	1883		
John McDonald, M.D.	wasnington	state Society			
E II Ivle MT	Franklin	Gov. T. J. Jarvis	1883		
W. G. Simmons, Chemist	Wake Forest	Gov. T. J. Jarvis	1883		
Arthur Winslow, Civil Engineer	Raleigh	Gov. T. J. Jarvis	1884		
R. H. Lewis, M.D.		State Board of Health	1884		
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1885	to	1887
Thomas F. Wood, W.D., Secretary	Ashovillo	State Society	1885		
William D. Hilliard, M.D.	Asnevine	State Society	1885		
Arthur Winslow, Civil Engineer		Gov. A. M. Scales	1885		
W. G. Simmons, Chemist	Wake Forest	Gov. A. M. Scales			
J. H. Tucker, M.D.	Henderson	Gov. A. M. Scales	1885		
R. H. Lewis, M.D., Secretary	Raleigh	State Society	1887	to	1888
H. T. Bahnson, M.D., President	Winston	State Society	1887	to	1888
H. I. Dallison, W.D., Fleshell	Relaigh	Gov. A. M. Scales	1887	to	1889
Arthur Winslow, Civil Engineer	Rateigh	Cou A M Scales	1887		
W. G. Simmons, Chemist	wake Forest	Gov. A. M. Scales	1888		
J. H. Tucker, M.D.	Henderson	Gov. A. M. Scales			
J. L. Ludlow, Civil Engineer J. H. Tucker, M.D.	. Winston	Gov. A. M. Scales	1888		
J. H. Tucker, M.D.	. Henderson	[Gov. D. G. Fowle	1888		
F. P. Venable, Ph.D. Chemist	ichanel Hill	Gov. D. G. Fowle	1889		
J. L. Ludlow, Civil Engineer	IW/instan	Gov D G. Fowle	1889	to	1892
J. D. Hudrow, Olvin Engineer	Favetteville	State Society	1889	to	1893
J. A. Hodges, M.D.	Torboro	State Society	1891	to	1893
J. M. Baker, M.D.	Tarboro	State Society Gov. T. M. Holt Gov. T. M. Holt Gov. T. M. Holt	1891	to	1893
J. H. Tucker, M.D. F. P. Venable, Ph.D., Chemist	Henderson	. Gov. 1. W. non	1891		
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. T. M. Holt			
J. L. Ludlow, Civil Engineer	Winston	Gov. T. M. Holt	1892		
Thomas F. Wood, M.D., Secretaryt	Wilmington	State Society	1891		
George G Thomas M.D. President	Wilmington	State Board of Health	1892	to	1895
E Westrey Pottle MD	Ashavilla	State Society	1893	to	1895
5. Westray Battle, W.D.	Williamston	State Society	1893	to	1895
W. H. Harrell, M.D.	C-1-h	State Board of Health	1893	to	1895
John Whitehead, M.D.	Dansbury	O- Plica Com	1893	to	1895
W. H. G. Lucas	wnite Hail	GOV. Elias Carr	1893	to	1205
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. Elias Carr	1093	10	1000
John C. Chase, Civil Engineer	- Wilmington	- Gov. Elias Carr	1894		
R. H. Lewis, M.D., Secretary	Raleigh	Gov. Elias Carr	1895		
W D Daell MD	Greensboro	Gov. Elias Carr	1895	to	
W. I. Lumadon M.D.	Flizabeth City	Gov Elias Carr	1895		1897
w. J. Lumsden, M.D.	Caliabanes	State Society	1895		1897
John Whitehead, M.D.	_Sansbury	Istate Society	1895	to	1897
W. H. Harrell, M.D.	- Williamston	State Society	1895	to	1897
W. P. Beall, M.D.	_ Greensboro	Gov. Elias Carr	1095		
R. H. Lewis, M.D., Secretary	Raleigh	Gov. Elias Carr	1897	to	1899
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. Elias Carr	1897		1899
John C Chase Civil Engineer	Wilmington	Gov. Elias Carr	1897		1899
Charles I O'Hagan MD	Greenville	Gov. D. L. Russell	1897	to	1899
Unaries J. O nagan, M.D.	Coldshore	Gov D. L. Russell	1897	to	1899
John D. Spicer, M.D.		Gov D. L. Puscell	1899		1901
J. L. Nicholson, M.D.	_kichiands	Gov. D. L. Russell	1899		
R. H. Lewis, M.D., Secretary	_ Raleigh	- Gov. D. L. Kussell	1000		
A. W. Shaffer, Civil Engineer	-Raleigh	Gov. D. L. Russell	1899		
Charles J. O'Hagan, M.D.	-Greenville	Gov. D. L. Russell	1899		
I I Nicholson M D	Richlands	Gov. D. L. Russell	1899		1901
Albert Anderson M.D.	Wilson	Gov. D. L. Russell	1899		
J. L. Ludlow, Civil Engineer Thomas F. Wood, M.D., Secretary' George G. Thomas, M.D., President S. Westray Battle, M.D. W. H. Harrell, M.D. John Whitehead, M.D. W. H. G. Lucas F. P. Venable, Ph.D., Chemist John C. Chase, Civil Engineer R. H. Lewis, M.D., Secretary W. P. Beall, M.D. W. J. Lumsden, M.D. John Whitehead, M.D. W. H. Harrell, M.D. W. H. Harrell, M.D. R. H. Lewis, M.D., Secretary F. P. Venable, Ph.D., Chemist John C. Chase, Civil Engineer Charles J. O'Hagan, M.D. John D. Spicer, M.D. J. L. Nicholson, M.D. R. H. Lewis, M.D., Secretary A. W. Shaffer, Civil Engineer Charles J. O'Hagan, M.D. J. L. Nicholson, M.D. R. H. Lewis, M.D., Secretary A. W. Shaffer, Civil Engineer Charles J. O'Hagan, M.D. J. L. Nicholson, M.D. Albert Anderson, M.D. George G. Thomas, M.D., President	Wilmington	State Society	1899		
George G. Thomas, M.D., President	- AA HHHHHRPOH				

[†] Died in 1892, leaving a five-year unexpired term, which was filled by the Board

Name	Address	Appointed by		Teri	
S. Westray Battle, M.D.	Asheville	State Society	1899		
H. W. Lewis, M.D.	Jackson	- State Society	1899	to	1
H. H. Dodson, M.D.	Milton	State Society	1901		
R. H. Lewis, M.D., Secretary	Raleign	Gov. C. B. Aycock	1901		
V. P. Ivey, M.D.	Lenoir	Gov. C. B. Aycock	1901		
George G. Thomas, M.D., President rancis Duffy, M.D.	Wilmington	Gov. C. B. Aycock	1901		
L. Ludlow, Civil Engineer	Winsten	Gov. C. B. Aycock	1901		
. Westray Battle, M.D.	A sh crillo	Gov. C. B. Aycock	1901		
I. W. Lewis, M.D.	Tackson	State Society	1901		
V. H. Whitehead. M.D.	Rocky Mount	State Society	1901		
L. Nicholson, M.D	Richlands	State Society	1901		
L. Ludlow, Civil Engineer	Winston	Cov C P Avecals	1901		
Howell Way, M.D.	Waynesville	Gov. D. B. Glopp	1903 1905	to	
V. O. Spencer. M.D.	Winston	Gov D B Glonn	1905		
eorge G. Thomas M.D. President	Wilmington	State Society			
homas E. Anderson, M.D.	Statesville	State Society	1905 1907		
R. H. Lewis, M.D	Raleigh	Gov P B Glenn	1907		
E. C. Register, M.D.	Charlotte	Gov R B Glenn			
David T. Tayloe, M.D.	Washington	State Society	1907 1907		
ames A. Burroughs, M.D.1	Asheville	State Society	1907		
. E. Ashcraft. M.D.	lMonroe	State Board of Health	1909		
. L. Ludlow, Civil Engineer	- Winston-Salem	Gov W W Kitchin	1911		
I. Howell Way M.D. President	Waynesville	Gov W W Kitchin	1911		
V. O. Spencer, M.D.	Winston-Salem	Gov W W Kitchin	1911		
Thomas E. Anderson, M.D.	Statesville	State Society	1911		
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1913		
R. H. Lewis, M.D.	Raleigh	Gov Locke Craig	1913		
Edw. J. Wood. M.D.	Wilmington	Gov Locke Craig	1913		
A. A. Kent. M.D.2	Lengir	State Society	1913		
Cyrus Thompson, M.D.	Jacksonville	State Society	1913		
letcher R. Harris, M.D.	Henderson	_ State Board of Health	1915		
. L. Ludlow, Civil Engineer	Winston-Salem	Gov. Locke Craig	1917		
Howell Way, M.D., President	Waynesville	Gov. T. W. Bickett	1917		
E. C. Register, M.D.1	Charlotte	Gov. T. W. Bickett	1917		
Thomas E. Anderson, M.D.	Statesville	State Society	1917		
Charles O'H. Laughinghouse, M.D	Greenville	State Society	1919		
Fletcher R. Harris, M.D. ³	Henderson	State Society	1919		
A. J. Crowell, M.D.	Charlotte	Gov. T. W. Bickett	1921	to	
Chas. E. Waddell, C. E.	Asheville	Gov. C. Morrison	1919	to	
Cyrus Thompson, M.D.	Jacksonville	State Society	1919	to	
R. H. Lewis, M.D.	Raleigh	Gov. T. W. Bickett	1923	to	1
L. J. Tucker, D.D.S.	Roxboro	Gov. T. W. Bickett	1923	to	ij
. Howell Way, M.D., President	Waynesville	Gov. C. Morrison	1923		
J. Crowell, M.D.	Charlotte	Gov. C. Morrison	1923		
James P. Stowe, Ph.G.	Charlotte	Gov. C. Morrison	1923		
D. A. Stanton, M.D.	High Point	State Board of Health	1923		
Thomas E. Anderson, M.D.	Statesville	State Society	1923		
Charles O'H. Laughinghouse, M.D. ⁵ Cyrus Thompson, M.D. ¹	Greenville	State Society	1925		
yrus Thompson, M.D.	Jacksonville	- State Society	1925		
D. A. Stanton, M.D.	High Point	State Society	1925		
R. H. Lewis, M.D.1	Raleigh	Gov. A. W. McLean	1926		
no. B. Wright, M.D.	- Raieigh	Gov. A. W. McLean	1925		
J. Tucker, D.D.S. ⁶	- Roxboro	Gov. A. W. McLean	1926		
V. S. Rankin, M.D. ⁴ E. McDaniel, M.D.	Charlotte	state Board of Health	1927		
Chos C. Orr M.D.	- Jackson	state Board of Health	1927		
Chas. C. Orr, M.D.	asneville	Gov. A. W. McLean	1929		
Thomas E. Anderson, M.D.*	- Statesville	State Society	1929		
ames P. Stowe, Ph.G.6	Jackson	Con A W Mar	1927		
J. Crowell, M.D.	Charlotte	Gov. A. W. McLean	1929		
. M. Parrott, M.D.	Zinston	State Board of House	1930		
Chas. C. Orr, M.D.	Ashavilla	Gov O Moy Cordner	1929		
M. Parrott M D 5	Kington	State Society	1931		
. M. Parrott, M.D.5 C. V. Reynolds, M.D.	Achavilla	State Society	1931		
B. Evans, M.D.	Windsor	State Society	1931		
D. Craig, M.D.	Winston-Solom	State Society	1931 1931		
ohn T. Burrus, M.D.	High Point	Gov O May Gardner			
N. Johnson, D.D.S.	Goldshoro	Gov O May Gordner	1931		
. A. Goode, Ph.G.	Asheville	Gov O May Gardner	1931 1931		
T T T 36 %	Dealer Mount	Gov. O. Max Gardner	1931		
1. L. Large. M.D					

Died leaving unexpired term.
 Resigned to become member of General Assembly.
 Resigned to become Health Officer Vance County.
 Resigned.

⁵ Resigned to become Secretary of State Board of Health 6 Term terminated on account of the reorganization of the State Board of Health by General Assembly.

Name	Address	Appointed by	Term
Grady G. Dixon, M.D.7	Ayden	Ex. Com. State Society	1931 to 1932
Grady G. Dixon, M.D.	Ayden	State Society	1932 to 1935
S. D. Craig, M.D. W. T. Rainey, M.D.	Winston-Salem	State Society	1933 to 1937
W. T. Rainey, M.D.	Goldshore	Gov. I. C. P. Ehringhous	1933 to 1937 1933 to 1937
J. N. Johnson, D.D.S. Hubert B. Haywood, M.D.	Poleigh	Gov. J. C. B. Enringhaus	1933 to 1937
James P. Stowe, Ph.G.	Charlotte	Gov. J. C. B. Ehringhaus	1933 to 1937
Grady G. Dixon, M.D.	Avden	State Society	1935 to 1939
J. LaBruce Ward, M.D.	Asheville	State Society	1935 to 1939
H. Lee Large, M.D.	Rocky Mount	State Society Gov. J. C. B. Ehringhaus _	1935 to 1939
H. G. Baity, C.E.	Chapel Hill	Gov. J. C. B. Ehringhaus	1935 to 1939
J N. Johnson, D.D.S.	Goldsboro	Gov. Clyde R. Hoey	1937 to 1941
Hubert B Haywood M.D.	Raleigh	Gov. Clyde R. Hoey	1937 to 1941
James P. Stowe, Ph.G. S. D. Craig, M.D. W. T. Rainey, M.D.	Charlotte	Gov. Clyde R. Hoey	1937 to 1941
S. D. Craig, M.D.	Winston-Salem	State Society	1937 to 1941
W. T. Rainey, M.D.	Fayetteville	State Society	1937 to 1941
Grady G Divon MD	Avden	istate Society	1939 to 1943
J. LaBruce Ward, M.D.	Asheville	State Society	1939 to 1943
H. Lee Large, M.D.	Rocky Mount	Gov. Clyde R. Hoey	1939 to 1943
H. G. Baity, Sc.D.	Chapel Hill	Gov. Clyde R. Hoey	1939 to 1943 1940 to 1943
C. C. Fordham, Jr., Ph.G.	Greensporo	Gov. Clyde R. Hoey	1940 to 1945
S. D. Craig, M.D. W. T. Rainey, M.D.	Willston-Salein	State Society	1941 to 1945
Hubert B. Haywood, M.D.	Paleigh	Gov. J. Melville Broughton	1941 to 1945
		Gov. J. Melville Broughton	1941 to 1945
James O. Nolan, M.D.	Kannapolis	Gov J Melville Broughton	1941 to 1945
Grady G. Dixon, M.D.	Avden	State Society	1943 to 1947
J. LaBruce Ward, M.D.	Asheville	State Society	1943 to 1947
H Lee Large M D	Rocky Mount	lGov. J. Melville Broughton	1943 to 1947
Larry I Moore Jr	Wilson	Gov. J. Melville Broughton	1943 to 1947
S D Craig M D Pres	Winston-Salem	State Society	1945 to 1949
W. T. Rainey, M.D. Hubert B. Haywood, M.D.	Fayetteville	State Society Gov. R. Gregg Cherry	1945 to 1949
Hubert B. Haywood, M.D.	Raleigh	Gov. R. Gregg Cherry	1945 to 1949
James O. Nolan, M.D.	Kannapous	Gov. R. Gregg Cherry	1945 to 1949 1946 to 1949
Paul Jones, D.D.S.9	Farmville	Gov. R. Gregg Cherry	1945 to 1949
Jasper C. Jackson, Ph.G.10	Lumberton	Gov. R. Gregg Cherry	1945 to 1947
Grady G. Dixon, M.D., Pres. H. Lee Large, M.D.	Ayden	Cov B Green Cherry	1947 to 1951
J. LaBruce Ward, M.D.	Ashoville	State Society	1947 to 1951
Hubert B. Haywood, M.D.	Poleigh	Gov W Kerr Scott	1949 to 1953
Mrs. James B. Hunt	Lucama	Gov W. Kerr Scott	1949 to 1953
A. C. Current, D.D.S.	Gastonia	Gov. W. Kerr Scott	1949 to 1953
John P Render M D	Winston-Salem	State Society	1949 to 1953
Benjamin J. Lawrence, M.D.	Raleigh	State Society	1949 to 1953
G. Grady Dixon, M.D.	Ayden	Medical Society	1951 to 1955
George Curtis Crump, M.D.	Asheville	Medical Society	1951 to 1955
John P. Henderson, Jr., M.D.11	Sneads Ferry	Gov. Wm. B. Umstead	1954 to 1955
H. C. Lutz, Phg.	Hickory	Gov. W. Kerr Scott	1951 to 1955 1953 to 1957
Hubert B. Haywood, M.D.12	Raleigh	Gov. wm. Umstead	1953 to 1957
Mrs. J. E. Latta	Hillsboro	Gov. Wm. Umstead	1953 to 1957
A. C. Current, D.D.S.	Gastonia	Modical Society	1953 to 1957
John R. Bender, M.D. Benjamin J. Lawrence, M.D.	winston-Salem	Medical Society	1953 to 1957
G. Grady Divon M.D. 5	Auden	Medical Society	1955 to 1959
G. Grady Dixon, M.D. ¹⁵ George Curtis Crump, M.D. ¹²	Asheville	Medical Society	1955 to 1959
Poger W Morrison M D 14	Acheville	Medical Society	1957 to 1957
Roger W. Morrison, M.D.14 John P. Henderson, Jr., M.D.	Speads Ferry	Gov. Luther H. Hodges	1955 to 1959
H. C. Lutz. Phg.	- Hickory	_COV. Lumer n. nouges	1955 to 1959
Lenox D. Baker, M.D.13	-{Durham	_ Gov. Luther H. Hoages	1956 to 1957
Earl W Brain MD16	Raleigh	Medical Society	1958 to 1959
Mrs. I. F. Latta	Hillshoro	Gov. Luther H. Hodges!	1957 to 1961
	Asheville	Medical Society	1957 to 1959 1957 to 1961
Roger W. Morrison, M.D.			
Roger W. Morrison, M.D. John R. Bender, M. D.	Winston-Salem	IMedical Society	
John R. Bender, M. D.	Winston-Salem	Gov. Luther H. Hodges	1957 to 1961
John B Bender M D	Winston-Salem Washington	Gov. Luther H. Hodges Medical Society	

⁷ To fill vacancy caused by resignation of Dr. J. M.
Parrott.
8 To fill vacancy caused by the death of James P.
Stowe, Ph.G.
9 To fill vacancy caused by resignation of J. N. Johnson, D.D.S.
10 To fill vacancy caused by resignation of Larry I.
Moore, Jr.

¹¹ To fill vacancy caused by the death of Dr. H. Lee Large.
12 Resigned
13 To fill vacancy caused by resignation of Dr. Hubert
14 Hawwood.
14 To fill vacancy caused by resignation of Dr. George Curtis Crump
15 Died leaving unexpired term.
16 To fill vacancy caused by the death of Dr. G. Grady Dixon.

ROSTER OF MEMBERS OF THE VARIOUS BOARDS OF MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA

FIRST BOARD	
James H. Dickson, Wilmington Charles E. Johnson, Raleigh Caleb Winslow, Hertford Otis F. Manson, Townsville William H. McKee, Raleigh Christopher Happoldt, Morganton J. Graham Tull, New Bern Samuel T. Iredell, Secretary	_1859-1866 _1859-1866 _1859-1866 _1859-1866 _1859-1866
SECOND BOARD	
N. J. Pittman, Tarboro E. Burke Haywood, Raleigh R. H. Winborne, Edenton S. S. Satchwell, Rocky Point J. J. Summerell, Salisbury R. B. Haywood, Raleigh M. Whitehead, Salisbury J. F. Shaffner, Salem William Little, Secretary Thomas F. Wood, Secretary, Wilmington	-1866-1872 -1866-1872 -1866-1872 -1866-1872 -1866-1872 -1866-1872
THIRD BOARD	
Charles J. O'Hagan, Greenville W. A. B. Norcom, Edenton C. Tate Murphy, Clinton George A. Foote, Warrenton J. W. Jones, Tarboro R. L. Payne, Lexington Charles Duffy, Jr., Secretary, New Bern	_1872-1878 _1872-1878 _1872-1878 _1872-1878
FOURTH BOARD	
Peter E. Hines, Raleigh Thomas D. Haigh, Fayetteville George L. Kirby, Goldsboro Thomas F. Wood, Wilmington Joseph Graham, Charlotte Robert I. Hicks, Williamston ¹ Richard H. Lewis, Raleigh ² Henry T. Bahnson, Secretary, Salem	.1878-1884 .1878-1884 .1878-1884 .1878-1884 .1878-1880
FIFTH BOARD	
William R. Wood, Scotland Neck Augustus W. Knox, Raleigh Francis Duffy, New Bern Patrick L. Murphy, Morganton Willis Alston, Littleton J. A. Reagan, Weaverville W. J. H. Bellamy, Secretary, Wilmington	1884-1890 1884-1890
SIXTH AND SEVENTH BOARDS	
R. L. Payne, Jr., Lexington George W. Purefoy, Asheville George G. Thomas, Wilmington Robert S. Young, Concord William H. Whitehead, Rocky Mount George W. Long, Graham L. J. Picot, Secretary, Littleton Julian M. Baker, Tarboro H. B. Weaver, Secretary, Asheville J. M. Hays, Greensboro ⁴ Kemp P. Battle, Jr., Raleigh ⁵ Thomas S. Burbank, Wilmington ¹ Richard H. Whitehead, Chapel Hill ⁴ William H. H. Cobb, Goldsboro ⁶ J. Howell Way, Secretary, Waynesville ⁷ David T. Tayloe, Washington Thomas E. Anderson, Sec., Statesville	1890-1894 1890-1894 1890-1896 1890-1896 1890-1896 1890-1896 1892-1898 1892-1898 1892-1898 1894-1897 1894-1897 1894-1898 1896-1898 1898-1900 1898-1900
Albert Anderson, Wilson ⁴ Edward C. Register, Charlotte ⁸ Thomas S. McMullan, Hertford ⁸	1896-1902 1898-1902 1900-1902
John C. Walton ⁸	1900-1902

EIGHTH BOARD

A. A. Kent, Lenoir	1902-1908
Charles O'H. Laughinghouse, Greenville	1902-1903
M. H. Fletcher, Asheville	
James M. Parrott, Kinston	1902-1903
J. T. J. Battle, Greensboro	1902-1908
Frank H. Russell, Wilmington	1902-1908
George W. Pressly, Secretary, Charlotte1	1902-1906
G. T. Sikes, Secretary, Grissom9	1906-1908
NOWN BOARD	
NINTH BOARD	
Lewis B. McBrayer, Asheville	1903-1914
John C. Rodman, Washington	1908-1914
William W. McKenzie, Salisbury	1908-1914

John Bynum, Winston-Salem 1908-1914 J. L. Nicholson, Richlands 1908-1914 Benj. K. Hays, Secretary, Oxford _____1908-1914

Henry H. Dodson, Greensboro _____1908-1914

TENTH BOARD	
Isaac M. Taylor, Morganton	1914-1920
John Q. Myers, Charlotte	1914-1920
Jacob F. Highsmith, Fayetteville	1914-1920
Martin L. Stevens, Asheville	1914-1920
Charles T. Harper, Wilmington4	1914-1915
Edwin G. Moore, Elm City10	1915-1920
John G. Blount, Washington11	1914-1920
Hubert A. Royster, Secretary, Raleigh	1914-1920

ELEVENTH BOARD

Lester A. Crowell, Lincolnton	1920-1926
William P. Holt, Duke	1920-1926
J. Gerald Murphy, Wilmington	
Lucius N. Glenn, Gastonia	1920-1926
Clarence A. Shore, Raleigh	1920-1926
William M. Jones, Greensboro	
Kemp P. B. Bonner, Sec., Morehead City	1920-1926

TWELFTH BOARD

I Wall III Boints	
Paul H. Ringer, Asheville	1926-1932
W. Houston Moore, Wilmington	
T. W. M. Long, Roanoke Rapids	
W. W. Dawson, Grifton ⁴	
J. K. Pepper, Winston-Salem	
Foy Roberson, Durham	
John W. McConnell, Secretary, Davidson	
David T. Tayloe, Jr., Washington ¹²	1930-1932

THIRTEENTH BOARD

Ben F. Royal, Morehead City	_1932-1938
Benj. J. Lawrence, Secretary, Raleigh	_1932-1938
F. Webb Griffith, Asheville	_1932-1933
Hamliton W. McKay, Charlotte	_1932-1938
J. W. Vernon, Morganton	_1932-1933
W. H. Smith, Goldsboro	_1932-1938
K. G. Averitt, Cedar Creek+	_1932-1936
Roscoe D. McMillan Red Springs13	1936-1938

13 Elected to serve unexpired term of Dr. Averitt,

¹ Resigned before expiration of term.
2 Elected for unexpired term of Dr. Hicks.
3 In 1890 the Medical Society of the State of North Carolina adopted the plan of electing members of the Board in such a manner that the terms would expire at different intervals of two years. This practice was followed for twelve years, or until 1902, when the plan was abandoned; an equivalent of two terms of six years each. It is evident that the Society arranged to abandon the policy as early as 1898, as two members were elected for short terms, and two years later two other members were elected for still shorter terms. It is therefore impossible to separate the sixth and seven Boards, since the membership was overlapping.
4 Died before the expiration of his term.
5 Elected to serve unexpired term of Dr. Hays.
6 Elected to serve the unexpired term of Dr. Burbank.
7 Elected to serve the unexpired term of Dr. Whithead.
8 Elected for short term expiring in 1902.
9 Elected to serve the unexpired term of Dr. Pressly.
10 Elected to serve the unexpired term of Dr. Happer.
11 Died a few months before the expiration of his term; such a short time that the vacancy was not filled.
12 Elected to serve unexpired term of Dr. W. W. Dawson.
13 Elected to serve unexpired term of Dr. Averitt,

SOIT EEMENT	
FOURTEENTH BOARD	1931-F. C. Smith, M.D. Charlotte
Karl B. Pace, Greenville 1938-1944	"Practical Value of Perimetry in Intracranial
William M. Coppridge Durham 1938-1944	Conditions; Case Reports' (tumors, vascular
William M. Coppridge, Durham 1938-1944 Frank A. Sharpe, Greensboro 1938-1944 Lowis W. Flies Ashevilled 1938-1943	disease, toxemia, syphillis and trauma.)
	From Section on Eye, Ear, Nose and Throat)
I I Street Brewer Roseboro	1932—Charles I. Allen, M.D. Wadesboro
W D James Secretary Hamlet1938-1944	"An Improved Splint for Treating Fractures of
I. A. Crowell, Jr., Lincolnton 1938-1944	the Lower Extremity Showing Reduction and
John LaBruce Ward, Asheville ¹⁴ 1943-1944	Skeletal Distraction Attachments"
FIFTEENTH BOARD	(From Section on Surgery)
C. W. Armstrong, Salisbury 1944-1950	1933—H. L. Sloan, M.D. Charlotte
Paul G Parker Erwin 1944-1950	"Some General Remarks about Cataract Sur-
M D Bonner Jamestown 1944-1950	gery, With Report of 100 Consecutive Un-
T. Leslie Lee, Kinston 1944-1950	complicated Cataract Operations" (From Section on Ophthalmology and Oto-
Roy B. McKnight, Charlotte 1944-1950	laryngology)
M. A. Pittman, Wilson1944-1950	
Ivan M. Procter, Secretary, Raleigh 1944-1950	J. R. Adams, M.D. Charlotte "Hypo-glycaemia in Children"
James B. Bullitt, Chapel Hill ¹⁵ 1949-1950	(From Section on Pediatrics)
Paul F. Whitaker, Kinston ¹⁶ 1950	1934—Fred E. Motley, M.D. Charlotte
SIXTEENTH BOARD	"Complications of Mastoiditis with Special Re-
Amos N Johnson Garland 1950-1956	ference to Septicemia"
Heyward C. Thompson, Shelby 1950-1956	(From Section on Ophtalmology and Oto-
James P. Rousseau, Winston-Salem1950-1956	laryngology)
Newsom P Battle Rocky Mount1950-1956	1935—Arthur H. London, M.D. Durham
Clyde R. Hedrick, Lenoir 1950-1956	"The Composition of an Average Pediatrics
L. Randolph Doffermyre, Dunn 1950-1956	Practice" (From Section on Pediatrics)
G. Westbrook Murphy, Asheville ¹⁷ 1955	
Joseph J. Combs, Secretary, Raleigh 1950-1956	1936—V. K. Hart, M.D Charlotte "Etiological and Therapeutic Aspects of Bron-
SEVENTEENTH BOARD	chiectasis with Clinical Observations on Bron-
Carl Vann Tyner, M.D., Leaksville 1956-1962	chial Lavage by the Stitt Method"
Joseph John Combs, M.D., Raleigh 1956-1962	(From Section on Ophthalmology and Oto-
John Bascom Anderson, M. D., Asheville _ 1956-1962	laryngology)
Thomas Williams Baker, M.D., Charlotte 1956-1962	1937No award made.
Edwin Albert Rasberry, Jr., M.D., Wilson1956-1962	1938—O. Hunter Jones, M.D. Charlotte
Thomas G. Thurston, M.D., Salisbury 1956-1962	"Pelvic Architecture and Classification with
Luther Randolph Doffermyre, M.D., Dunn 1956-1962	its Practical Application"
14 Elected to serve unexpired term of Dr. Elias. 15 Elected to serve unexpired term of Dr. T. Leslie Lee. 16 Elected to serve unexpired term of Dr. Paul G. Parker. 17 Elected to serve unexpired term of Dr. James P.	(From Section on Gynecology and Obstetrics)
15 Elected to serve unexpired term of Dr. T. Leslie Lee.	1939—Donnell B. Cobb, M.D
17 Elected to serve unexpired term of Dr. James P.	"Vaginal Ureterolithotomy"
Rousseau.	(From Section on Surgery)
	1940-C. R. Monroe, M.D., C. D. Thomas, M.D., and
APPARAT AWADDO	C. L. Gray, M.D. Pinehurst "Thoracoplasty and Apicolysis"
MEDICAL AWARDS	(From Section on Surgery)
	1941—Walter R. Johnson, M.D
MOORE COUNTY MEDICAL SOCIETY MEDAL	ease?"
In 1927 the Moore County Medical Society establish-	(From Section on Practice of Medicine)
ed a fund, the interest from which is used to pay for	1942—E. P. Alyea, M.D. Durham
a medal to be given for the best paper read at the	"Castration for Carcinoma of the Prostate
State Society meeting each year. No one is eligible to	Gland"
receive this medal except Fellows of the Medical Society of the State of North Carolina in good stand-	(From Section on Surgery)
ing: no invited guest is allowed to compete.	1943—No award made.
Each Section Chairman selects a committee of three	1944—D. F. Milam, M.D. Chapel Hill
to decide on the best paper written in their section.	"Vitamin C Content of Some North Carolina
The winning papers are then turned over to the State	Cooked Foods"
Committee, who select the one to receive the medal.	(From Section on Public Helath and Educa-
The following Fellows have been awarded this medal:	tion)
1928—Paul Pressly McCain, M.D. Sanatorium	1945—No Meeting.
"The Diagnosis and Significance of Juvenile	1946—E. C. Hamblen, M.D
Tuberculosis"	"Some Aspects of Sex Endocrinology in Gen-
(From Section on Pediatrics)	eral Practice"
1929—A. B. Holmes, M.D Fairmont	(From Section on General Practice of
"The Treatment of Uremia"	Medicine and Surgery)
(From Section on Chemistry, Materia Medica	1947—W. L. Thomas, M.D. Durham "Some Psychosomatic Problems in Gyne-
and Therapeutics)	"Some Psychosomatic Problems in Gyne- cology"
	(From Section on Gynecology and Obstetrics)
1930—C. T. Smith, M.D., and W. Bernard	1948—Felda Hightower, M.DWinston-Salem
Kinlaw, M.D. Rocky Mount "The Clinical Consideration of Anaemia of	"The Control of Electrolyte and Water
Pregnancy and of Puerperium'	Balance in Surgical Patients"
(From Section on Practice of Medicine)	(From Section on Surgery)

14 1949-George J. Baylin, M.D. Durham 1954—Paul Kimmelstiel, M.D. "The Roentgen Aspect of Non-Opaque Pulmonary Foreign Bodies" (From Section on Radiology) 1950-Parker R. Beamer, M.D. (From Section on Pathology) 1951-John P. U. McLeod, M.D. Endocrine Activity (From Section on Pediatrics) 1953—Harrie R. Chamberlin, M.D. to Organic Phosphate Insecticides" (From Section on Pediatrics) THE GEORGE MARION COOPER AWARD The Fellows of the Wake County Medical Society have been awarded this medal: 1951—Donald L. Whitener, M.D.Winston-Salem "The Management of Labor and Delivery in

_Winston-Salem "Studies on Experimental Leptospirosis" Marshville 'A Simplified Modification for Staining of the Vaginal Smear for Immediate Appraisal of (From Section on Gynecology and Obstetrics)

1952—Samuel F. Ravenel, M.D. .____Greensboro "Humidification in Pediatrics"

Chapel Hill "Diagnosis and Management of Poisoning Due

"Obesity and the Public Health" (From Section on Public Health) 1956-Wm, M. Peck, M.D. McCai "The Changing Pattern of Tuberculosis" (Section PH&E

(From Section on Pathology)

1955-H. Hugh Bryan, M.D.

-Paul Kimmeistiel, M.D. Charlott Roland T. Pixley, M.D. Charlott John Crawford, M.D. Charlott "Statistical Review of Twenty-two Thousan

Cases Examined by Cervical Smears"

Charlot

Chapel Hi

1957—John R. Ashe, Jr., M.D. Concor John V. Arey, M.D.
"The Use of Diamox in Obstetrics and Concor Gynecology" (From Section on Obstetrics and Gynecology

1958-John O. Lafferty, M.D. "Peptic Ulcers in Children" (From Section on Radiology)

1958-Madison S. Spach, M.D. Jerome S. Harris, M.D. (From Section on Pediatrics)

this George Marion Cooper Award established in honor of George Marion Cooper, physician and health benefactor. This medal is awarded by the Fellows of the Wake

County Medical Society as a token of appreciation and esteem in recognition of the eminence of an essay contributing to the knowledge and advancement of the science of medicine in the field of Preventive Medicine, Public Health, or Maternal and Infant Health Care, presented before the Medical Society of the State of North Carolina, The following Fellows

the Interest of the Premature Infant" (From Section on Gynecology and Obstetrics)

1952-Ronald Stephen, M.D. Senior Author; Duke University Durham "The Evaluation of Methods of Pain Relief During Labor and Delivery with Reference to Mother and Child." (From Section on Gynecology and Obstetrics)

Fever' (From the Section on Practice of Medicine)

1954—Richard L. Pearse, M.D. Durham Eleanor Easley, M.D. Durham Kenneth Podger, M.D. "Obstetric Analgesia and Anesthesia" (From Section on Obstetrics and Gynecology)

Huntersville 1955-Dirk Verhoeff, M.D. William M. Peck, M.D. McCain "The Trends in Management of Tuberculosis in Children" (From Section on Pediatrics)

1956-Benjamin A. Johnson, M.D. Susan C. Dees, M.D. "Immunization of Allergic Children with Particular Reference to Eczema Vaccinatum" (Section on Pediatrics)

1957-Walter A. Sikes, M.D. John D. Patton, M.D. Asheville
Robert L. Craig, M.D. Asheville
Marie Baldwin, M.D. Asheville
Anne Sagberg, M.D. Asheville Anne Sagberg, M.D. Asheville
R. Charman Carroll, M.D. Asheville
"Trends in the Dand-"Trends in the Development of an Open Psychiatric Hospital" (From Section on Neurology and Psychiatry)

"Congential Heart Disease in Infancy"

GASTON COUNTY MEDICAL SOCIETY AWARD By authority of the House of Delegates an awar is established by the Gaston County Medical Societ for the best presentation of audio-visual material i scientific treatise and will be awarded to the bes presentation annually at the Annual Session of th State Society. Competition will be restricted to au dio-visual material as provided by the rules. Pro gram Chairmen of the eleven scientific sections should take note of this in the preparation of the 1956 pro gram and in judging of presentations at the Annua Session in 1956. The following Fellows have been awarded this medal:

1952—Kenneth L. Pickrell, M.D. Durhan "Tattooing the Cornea" (From Scientific Exhibits)

1953-Joseph E. Markee, M.D. Durhan "Autonomic Nervous System" (Film from Audio-Visual Postgraduate Instructional Program)

1954-William H. Boyce, M.D....Winston-Salen Fred K. Garvey, M.D. _____Winston-Salen Charles M. Norfleet, M. D. ____Winston-Salen "Biocolloids of Urine in Health and in Calculou-Disease" (From Scientific Exhibits)

1955-Caleb Young, M.D. Winston-Salen "Congenital Dislocation of the Hip"

(A motion picture) (From Postgraduate Audio-Visual Program)

Durhan 1956—C. R. Stephen, M.D. R. C. Martin, M.D. Durhan Durhan Bourgeois-Gavardin. Bourgeois-Gavardin.

"Prophylaxis of Non-Hemolytic Transfusior Reactions: Value of Pyribenzamine" (Section on Anesthesia)

1957-J. Leonard Goldner, M.D. Mr. Bert Titus. Durhan "The Juvenile Amputee-Upper Extremity" (From Section on General Practice of Medicine)

1958-T. Franklin Williams, M.D. J. L. DeWalt, M.D. R. W. Winter, M.D. Charles H. Burnett, M.D.
"Newer Diagnostic Criteria In Hyperparathyroidism" (From 1958 Scientific Exhibits)

EXECUTIVE COUNCIL MEETINGS

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA PROCEEDINGS OF EXECUTIVE COUNCIL SATURDAY AFTERNOON SESSION May 2, 1959

The Executive Council Meeting held in connection with the 105th Annual Session of the Medical Society of the State of North Carolina convened in the Grove Room of the Battery Park Hotel, Asheville, North Carolina, Saturday, May 2, 1959, at two o'clock, President Lenox D. Baker presiding.

PRESIDENT BAKER: We now have a quorum. I will call this meeting to order and ask Dr. Paschal to open it with the invocation.

DR. PASCHAL: (Dr. Paschal rendered

an invocation).

PRESIDENT BAKER: I have no special announcements, and I don't know anything we have to have an executive session of the Committee meeting about at this time, so I will ask Dr. John Rhodes to call the roll.

(The roll was called, and 17 voting mem-

bers answered present.)

SECRETARY RHODES: A quorum is present.

PRESIDENT BAKER: I hereby declare

we have a quorum.

The next item is the Minutes of the pre-

vious meetings.

MR. BARNES: Dr. Baker, the Minutes have been abridged into what we term a Report of the Executive Council to the House of Delegates, and each member of the Council, I believe for the first time in history, has had copies of it. This represents a 17-page abridgment of some 500 typewritten pages of the proceedings of the Executive Council, and it will be the duty of the President to present this as a report to the House of Delegates.

Each delegate, as I say, has had a copy of it, also for the first time in history, and let

that be understood for the record.

DR. SAMS: I move that we dispense with the reading of the Minutes and adopt the report.

(The motion was seconded, was put to a

vote, and carried.)

PRESIDENT BAKER: It is accepted

and adopted.

The next thing is discussion of Board structures in which this Society participates—elections.

We have the expiring term on the Medical Care Commission of Bill Coppridge, who has done an excellent job there. His four-year term, however, expires as of June 30, 1959.

Do I have any suggestions? Does this Council usually make a suggestion? Actually, these nominations have to come from the floor, don't they?

MR. BARNES: These nominations have to come from the floor of the House of Delegates, and the reason for ever bringing it up in the agenda of the Executive Council is that there would be some alert consideration of competent men to be nominated for these positions representative of the Society on these State Commissions and public boards of trustees.

Up until this time these particular offices have been nominated from the floor of the General Sessions and elected there, but Secretary Rhodes has recently discovered that the By-Laws were amended about three years ago to provide that these elections be in the House of Delegates and that they come from the nominations from the floor.

PRESIDENT BAKER: That is what we did last year. We did it in the General Session last year. We now propose to do it in the House of Delegates. I want to call that to your attention, that that is a change in the election procedure. As I understand, it applies to any person that is elected by the Medical Society to any sort of board, including our own Editorial Board.

The next subject is Hospital Saving Trus-

tee

DR. KOONCE: I think we are a little presumptuous if we try to direct.

DR. SAMS: I move we refer this to the House of Delegates for their consideration.

PRESIDENT BAKER: Going to resolutions and communications is Harnett County Medical Society Resolution.

MR. BARNES: This is a letter addressed to Dr. Baker under date of March 16, 1959 by Dr. Bruce B. Blackmon, President of the Harnett County Medical Society:

The Harnett County Medical Society has instructed me to write to you. We have a resolution we would like to present to the House of Delegates in May. Because of the nature of the resolution, we would like to present it to the Executive Council for their approval or disapproval before going before the House of Delegates. In this way we feel that we would have the

benefit of the thinking of some of the best men of medicine. If the Executive Council feels that we are not acting in the best interest of North Carolina Medicine, we can withdraw our resolution before it ever goes to the House of Delegates and thus avoid the inherent dangers of adverse publicity for the Society which is always a possibility when men of medicine raise a voice.

Can you arrange an audience for us with the Executive Council for this purpose? If you would like to discuss this matter in person, some of us would be glad to run up to Durham and discuss this with you.

I trust your physical condition is im-

proving.

Sincerely, Bruce B. Blackmon

No resolution accompanied this letter. PRESIDENT BAKER: I called Dr. Blackmon and told him we would be glad to hear him, and I thought he ought to come before us. Did I sent you that correspondence?

MR. BARNES: Yes.

PRESIDENT BAKER: Thus far we have not received the resolution. I think we can let it stand as it is until we get it.

The next thing is the Martin-Washington-Tyrrell County Medical Society Resolution,

which is a right good one, I think.

MR. BARNES:This is a resolution directed to the Secretaries of all component units of the Medical Society of the State of North Carolina in a communication that is undated but following an action of the Martin-Washington-Tyrrell County Society on April 1, 1959. It says:

Dear Sir: The following resolution was unanimously passed by the Martin-Washington-Tyrrell Counties Medical Society at their regular meeting on April 1, 1959. Because of the statewide importance of this subject, the society membership has voted to inform all component societies of the North Carolina Medical Society of our action. The resolution follows:

Whereas, The compulsory automobile liability insurance law now in force in North Carolina requires no provision for damages to the owner (and, usually, the driver) of a motor vehicle for injuries sustained by himself, and

Whereas, Hospitals, doctors and other medical facilities in North Carolina have suffered considerable financial loss in furnishing medical care and services to persons injured in automobile accidents who were not eligible for benefits under policies currently required by the compulsory insurance law, and

Whereas, A change in the present compulsory insurance law to require every registered motor vehicle owner in North Carolina to carry a medical payments clause in addition to the liability insurance already required would relieve this in-

equity, now therefore, be it.

RESOLVED, That the Martin-Washington-Tyrrell Counties Medical Society unanimously favors an amendment to the present compulsory automobile insurance act to require every registered owner of a motor vehicle in the State of North Carolina to carry a medical payments clause in addition to the liability insurance already required by law before he may allow that vehicle to be operated on the public highways of North Carolina.

Passed unanimously April 1, 1959. Joseph M. Ward, President Walter E. Ward, Secretary

PRESIDENT BAKER: I replied to that communication to the effect that I thought they had something that the Medical Society would back. I did not think it should be initiated by us because it did not have to do with health, and I thought the hospitals should certainly back it, but I thought that they would get farther in the General Assembly if they got the County Commissioners, which is a pretty well organized group of people in this state, to back this on the basis that the County Commissioners are having to raise the tax to support the hospital when they get rooked on a man who does not pay his bill.

I asked them to see you, John. Did they

do so?

MR, ANDERSON: No, sir.

DR. SAMS: I heartily agree with the resolution. I think all of us would be for it, but I can prove by my friend, Bridger, over there, and John Anderson and Jim Barnes that it would have just about as much show in the Legislature as a snowball in torment. It doesn't hurt to ask for it, however.

PRESIDENT BAKER: Unless the County Commissioner shows the legislature that the

state is losing the money.

Does anyone want to approve my reply to this letter so we can take some action on this?

(The reply to the letter was not handed to the reporter for inclusion in the transcript.)

DR. BRINN: I move that Dr. Baker's

reply to this letter be approved.

(The motion was seconded, was put to a

vote and carried.)

PRESIDENT BAKER: Next is a resolution of the Chatham County Medical Society. I believe Dr. Garrison and Dr. Paschal should listen to this one:

A Resolution to transfer membership of the Chatham County Medical Society from the Fifth Medical District to the Sixth Medical District.

Whereas, The Chatham County Medical Society geographically is closer to the activities of the Sixth Medical District, and

Whereas, The Chatham County Medical Society has unanimously voted to ask for the change of membership from the Fifth Medical District to the Sixth Medical District,

RESOLVED, That the Chatham County Medical Society, by action of the House of Delegates, become a member of the Sixth Medical District.

DR. GARRISON: I think they should be allowed to do so in the Sixth District because they are so far from the counties in our area that they do not attend the district meetings.

PRESIDENT BAKER: Are there any comments from you, Dr. Paschal?

DR. PASCHAL: In so far as I know, there is no objection on the part of the members of the Sixth District. They have not been individually polled.

PRESIDENT BAKER: You have heard the two Councilors involved. Neither one of them is against this. Do I hear a motion in

regard to it?

DR. SAMS: I move that the Council grant the request of the Chatham County Medical Society for approval of transfer and recommend the House of Delegates act on the matter.

MR. BARNES: The By-Laws have to be revised and there is a recommendation in the Committee on Constitution and By-Laws to do so.

PRESIDENT BAKER: The next item on the agenda is a letter from the Cumberland County Medical Society.

MR. BARNES: This is a letter directed to me under date of March 2 as Executive Secretary of the State Society in regard to Dr. Wade Parker of Fayetteville. It says:

"Please note enclosed carbon copy of letter to Dr. Parker. He has been officially restored to active status in the Cumberland County Medical Society, and it is hereby requested that the State Society take similar action."

You will recall some years ago Dr. Parker was involved in some court action and his membership in the State Society, under a provision of the Constitution and By-Laws, was automatically suspended. This letter is a request for action on the part of the State Society by the County Medical Society to restore his state membership. I see no reason

why you should not do what we have been askd to do.

PRESIDENT BAKER: That is the Dr. Parker who was connected with Dr. Pittman for so long.

DR. SAMS: Has that been before the Board

of Medical Examiners?

MR. BARNES: I have checked with the Board of Medical Examiners, and they tell me his license is in good standing at the present time.

DR. SAMS: I move that we restore the man to full membership in the State Society.

PRESIDENT BAKER: Do we have any comment from the Councilor of that district?

(There was no comment.) (The motion was seconded.)

PRESIDENT BAKER: Is there any further comment?

(The motion was put to a vote and car-

ried.)

PRESIDENT BAKER: Mr. Barnes says he has two resolutions from Mecklenburg County just handed to him.

MR. BARNES: I am going to read these. Resolution No. 1:

Whereas, The Joint Commission on Accreditation of Hospitals has, in the past few years, made rules for the accreditation of hospitals which are unreasonable and which are a distinct invasion of the private practice of medicine; to wit:

1. The regulation that each hospital maintain a "dangerous drug list" which requires that certain drugs listed as dangerous would be required by the hospital to be re-ordered at stated intervals.

2. The regulation that in addition to a certificate on the top sheet of the hospital chart certifying that the chart has been checked, a physician must also sign histories, physicals and O. R. notes, as well as a variety of orders and progress sheets, therefore be it

RESOLVED, That the Mecklenburg County Medical Society request the House of Delegates of the Medical Society of the State of North Carolina to convey objections to the House of Delegates of the AMA.

Submitted by a delegation from the Mecklenburg County Medical Society.

A copy of this resolution has been sent to all county societies in the State.

DR. SQUIRES: I would suggest that it would probably best be referred to a committee and try to coordinate the contents of such actions that have been taken by other groups. I make that as a motion, that it be referred to a committee.

PRESIDENT BAKER: The Committee on Hospital and Professional Relations?

DR. SQUIRES: Very well.

MR. BARNES: This resolution that the Maryland Association has presented was referred to the Committee on Hospital and Professional Relations, and they brought in a report. The Council instructed that a resolution be sent to the AMA Council on Medical Education and Hospitals, and it has been sent to them and they have it now under study. I don't know what sort of report they will bring in or whether they will bring in a report this year. It seems to me this ought to be added to that committee's activities and let them submit it to the AMA Council.

DR. SQUIRES: I move that this be referred to the proper committee and that it then be reported back to this Council.

(The motion was seconded.)

(The motion was put to a vote and carried)

PRESIDENT BAKER: It will be referred to the Committee on Hospital and Professional Relations.

MR. BARNES: The second resolution from Mecklenburg concerns a possible change of days-of-week meeting date for the Medical Society of North Carolina from first to last days:

Resolution Concerning Possible Change in Meeting Dates for the Medical Society of the State of North Carolina

DR. SQUIRES: That was given to me this morning by our President, and he stated that most cities and hotels were crowded on week-ends, and it would probably be best to have the meeting on Tuesday, Wednesday and Thursday rather than Monday, Tuesday and Wednesday, and have the Executive Council meeting on Monday rather than on a Saturday.

PRESIDENT BAKER: This has been brought up to us before, and I have inquired around among some people to see what they

thought.

Some people have said that as we now meet, this Council and other people responsible for getting away from home on a weekend, attend to some of the business, and actually get back and attend to their practice on Thursday, Friday and Saturday. If we try to have this Council meeting on Monday, that means the officers of the Society and the Committees are going to be gone an entire week. Thy leave home probably Sunday and will not get home until probably Saturday.

DR. SAMS: I move, then, that we dis-

approve the resolution.

(The motion was seconded by Dr. Brinn.) PRESIDENT BAKER: If it is to be reported, we shall ask Dr. R. Beverly Raney or someone on the Arrangements Commission to make it a part of his report rather than to have it come up as a resolution.

Will all who approve of the resolution as it now stands—this is in the negative—say "aye"; opposed likewise. The motion to dis-

approve is adopted.

A report of the Ad Hoc Committee on Text-Books which is a part of the Committee on Auxiliary and Archives of History, of which Dr. Roscoe McMillan is chairman, is to be given by Dr. Joseph Bowers. Most of you people were present in January. I think you remember that a committee from Kinston in that district came in with a report. We referred it to a committee and made that committee a part of Dr. Roscoe McMillan's committee, and as an ad hoc committee.

DR. BOWERS: After considerable study, we found a number of deficiencies in the textbook situation in the State. We have documentary proof that practically all the sociology books strongly favor socialized medicine. That is just a minor part of their deficiencies, but that is the thing in which we have a strong interest. They preach socialized medicine. We feel that they are poorly written, they are pseudo-science and give very little education. We feel that they are very inferior and that they should be replaced with a good American history course.

Investigating it further, we found a number of interesting things. One is that the National Education Association classically has a monopoly on the educational policies, and they dominate the local school boards.

We have letters from the Textbook Commission, and it appears that they cannot read all of the textbooks, and so the textbooks are channeled down to the teachers without having been read. They are sent to several different schools. Their acceptance is based more or less on recommendations of the authors and certain people's credentials, but they are not read by the Commission.

The local parent-teacher association has no authority to go into or even question the methods or the material that is used, so they cannot be approached from the local parent-teacher association because of the national by-laws of the Parent-Teacher Association prohibiting interference with school

administration.

We went further into this thing. We found out that the Sons of the American Revolution had a petition to the Congress of the United States for an investigation. It was channeled around to decide who was going to be head of an investigating committee. It got passed over to the Department of Health, Education and Welfare and therefore was just tabled.

We also found that the Daughters of the American Resolution and a number of members of the American Legion and other people have been working on this for a long

time and have not been getting very far. Dr. Whitaker has written to the local newspaper, and from that we got a local state textbook organization and they are studying it. We have got the local lawyers into it, and the same is true of practically everyone that we have talked to. In the case of the lawyers they are going to bring it to the State Bar Association and they are going to bring it with an angle of making an attempt to get the Textbook Commission they have twelve teachers that are appointed; they are all in the educational field—to go

In an informal conversation at a meeting we talked to the Chairman of the Board of Education, and in our conversation with him we found out that he was not aware of the situation, he was not aware that there was any controversy. This has not been taken up with the Textbook Commission nor has it been taken up with the State Board of Edu-

into this.

We can document all of those things. Also we sent bulletins of background material to all of the medical auxiliaries of all of the societies in the state.

I could talk for hours on this subject, and the more I read the more I am convinced of the wrongness prevailing. I am the least emotional of the group that has been studying it, and I have tried to be unbiased and impartial in my study of the thing. The more I read, the less I like the situation.

We are willing to go further in our studies. We will present some of the information to the delegates if you so desire, or we will go to the Textbook Commission or approach it through the Board of Education, anything that the Society would desire we go further in, in connection with this text-book situation.

PRESIDENT BAKER: Dr. Bowers, actually, the thing that is going to be done about this is going to be done through the Textbook Commission and nobody else, is that so? Is that the only group that has the power now of the Board of Education?

DR. BOWERS: Yes.

PRESIDENT BAKER: If we continue your committee as it now stands, can't you people work with the lawyers and others, and have one from each group on your committee, and then go to the Textbook Commission? Do you want us to have a resolution here approving this, or what would you like to have us do?

DR. BOWERS: We have not approached the Textbook Commission. We have done only those things that we have had permission from the Society to do, and that was to study this thing, and to approach to the local groups, and we have gotten fine cooperation from all of the groups that we have approached.

DR. GARRISON: Mr. President, this is a very important thing, but don't you think if this Council would recommend to the Auxiliary of the Society that something be done about this, women would be more likely to get the job done and work along on this?

PRESIDENT BAKER: That is what we have done before. We have referred this to the Committee on Auxiliary and Archives of History.

DR. GARRISON: I feel they will do a better job with the children than this group will do.

DR. BOWERS: Dr. Peele is talking to the Auxiliary. They have requested him to talk to them, and he is talking to them about this at this present annual meeting.

DR. GARRISON: I move that we accept the information and that we give the information to the Auxiliary as one of their projects for the next year and continue to work with this committee.

(The motion was seconded.)

PRESIDENT BAKER: Is there discussion? Will that suit your committee? We are favorably referring this. You will continue as is, is what that amounts to.

DR. BOWERS: Yes.

(The motion was put to a vote and carried.)

PRESIDENT BAKER: Dr. Shuford, you take a few notes as Commissioner on this and include it in your report to the House of Delegates Monday?

The next on the agenda is the AMA report on the Commission on Medical Care Plans—their findings, conclusions, and recommendations. I recommend to Mr. Barnes that that be broken down and referred to various committees within the Society.

MR. BARNES: A segment of the report was referred to Dr. Amos Johnson with

reference to the third party.

DR. AMOS JOHNSON: There is a volume of it and many preliminary reports. The whole thing is very interesting, and I think everybody here ought to be encouraged to dig out your copy that was issued as a supplement to the Journal of the AMA. This was a study that was recommended by the House of Delegates of the AMA in about 1955. An outstanding committee was set up to do this study, and they have been studying it for some three or four years now and have just come up with their final report.

The portion that was turned over to me to discuss involves some 55 pages of this report, and it deals with the Prepaid Medical Care Plans that are not generally accepted

all over the United States, such as the Blue

Cross, Blue Shield and the commercial companies plans that are accepted.

My report deals with plans such as the United Mine Workers, the United Garment Workers, the closed panel plans that are in operation more on the Pacific Coast than elsewhere. They are organizations of doctors that have set up their own insurance plans and are giving comprehensive medical care to members of these plans.

I can give you the headings under which they were evaluated and briefly touch on

them.

They were evaluated as to physicians participating in policy decisions of governing boards. Bear in mind this is dealing primarily with closed panels and sometimes partially open panels, limited panels, and some have a little bit of free choice.

With reference to medical care as it pertains to the medical plans of labor unions, the one that we are perhaps more familiar with than any other is the plan the United

Mine Workers are operating.

The report deals further with some of those plans that were organized by groups of doctors in the Far West who advertised and accumulated a group of people to whom they agreed to give total and complete medical care.

The physicians participating in the policy decisions of the governing boards were very poor. In most instances the governing board's administrator was not a doctor, and in instances where he was a doctor, very little cooperation was asked or gotten from the doctors who were on the panels of these medical programs.

As to physicians participating in the policy decisions on a staff level, very few of them have regular staff meetings. Thy have them say once every two weeks or once a month and ask that all the staff be there and discuss things in an open and straightforward manner as to what was best for the people who were receiving the medical care. The majority of them had rather haphazard staff meetings.

Medical advisory councils, that is, where

they had set up councils of medical men available outside of the medical men in the panel were also very insufficient.

Lay domination—the report states that there was very little evidence of actual lay domination but that the potential for lay domination was there in that the doctors both in and outside the panel had very, very little opportunity to express opinions, and few of them had any vote at all in these meetings. The majority of these plans had a lay person as executive secretary. There was definitely a potential of lay domination which as yet had not raised its head too high.

Composition and payment for professional staff—the pay ranged anywhere from some part-time, getting as little as \$5 an hour, to some of the super-specialists getting perhaps as much as \$25 an hour, and some in the retainer places getting as little as \$2000 a year. The highest salary that was reported here was \$25,000 a year for a full-time brain surgeon or some person like that.

Scope of programs, and their responsibility to patients—they varied anywhere from a simple diagnostic service where if you felt ill you went in, and a panel of diagnosticians did in their office or in the hospital a simple diagnostic work-up and then referred you back to another doctor. In the instances of that type of service, the doctors on the diagnostic panel insisted that the lay members of the panel whom they were examining have a family physician. It was all the way from full and comprehensive coverage in the office to ambulatory coverage in the home, house calls, in the hospital, total and complete theoretically paid in its entirety. But upon investigation it was found that those who went into that, as you would suspect, were a little bit hungry, and they were always giving additional shots or they only gave the house calls free during the day or they didn't give them on the week-end, or for certain medicines required additional pay, or certain procedures required additional pay. Actually and factually, there was no total comprehensive coverage in any of the plans. There were little loopholes while they picked up a few bucks here and ten bucks there. They were confused, and there was a tendency to breed a little disrespect for those particular plans among the people using them.

Relationship within the medical staff—that was not too bad. There was not much griping about the referral of patients from one to another or the patients being assigned to them, and that is in keeping with what you might suppose from the type of men who were to get involved in such a deal, that

perhaps they were more interested in what they were going to get from the 15th to the 1st—that was my observation—that they were not concerned too much about their relationship each with the other within the plan.

The relationship between the physicians and the medical societies—in most instances, the medical societies were aware of what was going on. In a considerable number of instances, particularly, I judge on the West Coast, some of the organizers and people most active in some of the medical care plans out there actually were office holders. In other areas, with which we are more familiar along the Eastern Seaboard and in the coal area there was quite a bit of strife. Some of them were not permitted to join the medical societies and could not join the AMA. Yet in the same area one member of the panel working for the United Mine Workers would be a member of the local medical society and another one wouldn't. There was no definite and precise plan. Certain of the less obnoxious plans were approved by the local medical societies and members were not taken in In some of the more obnoxious ones there was considerable controversy, and some were taken in and some were not.

Relationship with other physicians in the community—the relationship with other physicians in the community are just about on a par with what I have said as to the relationship with the medical societies as would naturally be expected.

On the West Coast, they are accepted, and there is very little enmity between those physicians not participating or who had not been invited to participate or who were not around when the plan was incorporated, and the others.

The extent of the physicians' selection by patients—not too much. Most of it is closed panel stuff, and within the closed panel after the initial examination they can have a limited degree of choice from those doctors on the panel, that is, some of them will have as many as a hundred, some a thousand, fifteen hundred or two thousand.

If they had a hundred in a Mine Workers' hospital, and you came in, you would first be assigned to a doctor for your examination. You would have no choice there. But then after that when you were referred to somebody, be it medicine or urology or whatever, you could have, within the two or four or six giving that service, some little bit of choice of doctors.

There were two or three plans that were studied where it was strictly an open panel field with very few exceptions, but in most instances there was a very limited, and in a considerable number of instances no choice at all.

Adequacy of facilities—the committee investigating found that the facilities that were made available under these plans were within bounds the same that most of the doctors had outside. In some instances they were perhaps a little bit better. There was no gripe at the adequacy of these facilities.

Continuity of care is where the major breakdown is, as I have picked it up from this report. In any of these groups the doctors work by hours. A doctor is on five days a week eight hours a day, and on the weekend he is off and one or two others are on. Then special ones are hired to come in and work a few days. So the care that is offered in the majority of cases under these plans is a rather episodic, sporadic type of medical care with very little continuity of medical history, rapport or the necessary psychosomatic understanding. The report would have to be interpreted as recording continuity of care as being insufficient.

Utilization of services—this was very good. I mean by that that service is there for them, they pay for it and in the majority of instances it has been provided by bargaining and bickering and has been paid for by big business that produces an object to be sold. and the cost of the care is passed on to that object.

In the instance of the United Mine Workers, when you burn a ton of coal, you pay a buck, or whatever the fee is, toward the care of these people. It is available for you. It may not be as good as you would like, but you are going to utilize it certainly as far as it may be efficient in your instance.

Preventive medicine—very little is practiced. Of course, in the comprehensive manner they do the vaccination of the children, do the immunilogical work on children and young people, they do cover that, but so far as actually practicing preventive medicine, it is not done. What they are substituting is early diagnosis of disease processes, which, in its finality, is not preventive medicine. It is purely an early diagnosis by virtue of the fact that the people have it prepaid and come in early, and also by virtue of their having laboratories and facilities for making these diagnoses earlier than they could on the outside. Actually, it is poor preventive medicine.

Relationship of payment for medical services to total income—the actual amount of money that is paid back to doctors, some lower, some higher, will run in the neighbodhood of about 35 or 40 per cent of the amount of money that is paid in, that is,

that amount goes back for professional service on a fee for service basis. It is not so much on a retainer and salary. The other 65 per cent goes for administration and hospitalization and drugs.

Record-keeping was not too good. Under the plans it seems that they are not quite as alert to keeping the records, having very detailed records of history and physical findings and things and the actual signing and

keeping up of the records.

Complaint and complaint procedures—in almost all instances of the larger ones, there is a procedure set up where a person can complain. They estimate that they have approximately one complaint a year for every 300 people enrolled in the plan. They estimate that they have one complaint per year for every 1700 to 2000 services rendered. But there is very little evidence that it goes too far investigatively. If it is a severe complaint, if it is a complaint that must be taken care of, they run it down. If they have complaints of excessive operations or things like that where a doctor is on a fee for service basis, they most certainly run that down.

Occupations and income of members—this was very enlightening and important. The majority of the members of these panels are in the laboring, low-income, ignorant class of people. They are the ones who are happy with it.

Some of the plans open it up and it takes all the whole scope of people working in plants up to those that are earning \$10,000, \$12,000, \$15,000 a year, and it has been found that after they pass about the \$6000 a year or maybe the \$4000 a year income bracket, they begin to get dissatisfied with the plans. They are used to better care, they have had their own private doctors before, and they are the ones that do the bulk of the complaining and do not utilize the service as well as the actual day laborer, the \$2000 or \$3000 a year person who has never had a private doctor before and who under this plan, it is specifically stated by this Commission, gets better medical care than he would get did he not belong to this plan because he would not avail himself of it on a fee-for-service basis out of his own pocket.

Literature promotion methods and advertising—they have very little feeling against promotional ideas. Actually, some of the plans on the West Coast that are gotten up by doctors who are in good standing ran ads in the paper and set up their panels that way, and they were not censured. I don't know what their code of ethics in those states is, but I don't believe in this state, according

to the code of ethics that we have set up, that that would set so very well here. I got the impression that most of the advertising was done by that type of organization rather than the unions because there they have them anyway and have very little advertising to do. A lot of them have their own weekly or monthly bulletin that they issue. It goes around to all of them who are taking the service and through them to their friends.

Attitude of medical society toward plans -that, we have more or less discussed. In the Far West it is not looked on as being so bad. In our eastern seaboard area, it is not highly regarded at all. However, it is brought out in about a half-page discussion here by the committee in their conclusions, that whether we like it or whether we don't we have to be particularly careful in every instance in what we may do toward censuring the members of our society for participating in these plans, particularly if the company involved is tangled up in interstate commerce. Then it would come under the jurisdiction of the Federal Government and the Harrison Anti-Trust Act would get into the picture. You would be liable for serious trouble in the federal courts possibly. If it is not a matter in interstate dealings, then each individual state has had or can give its own rulings and interpretation on its own statutes in the state.

The only remedy is to pursue that and get a favorable ruling, or, if you don't get a favorable ruling, to go to the legislature and set it up so that you have a statute that controls it within your state. But you cannot, without due consideration, jump the gun and throw somebody out for participating.

Attitudes, responses from participating physicians—I have covered that in the other portions of this talk.

That is in a very brief manner, I hope, a surface coating of a very interesting thing. It was interesting to me, and I am glad you asked me to present it. I did not particularly like it at the time, but I have enjoyed reading this, and I think that it would be very instructive to everyone here if you dug out your copy of this when you get back home and some Saturday night or Sunday afternoon read it because some of it will open your eyes.

PRESIDENT BAKER: What you have actually reported to us is that these families do not have freedom of choice of doctors. It is something they are paying for either with their labor or cash, and they do not

have freedom of choice.

DR. AMOS JOHNSON: Or we are paying

for it for them through the commodities that we buy.

DR. PASCHAL: I move that we accept

it as information.

(The motion was seconded, was put to a vote and carried.)

PRESIDENT BAKER: Thank you so

much, Amos, for a good report.

Dr. Shuford we will now hear your part

of this AMA report on Medical Plans.

DR. SHUFORD: I agree with Dr. Johnson. I had not read this prior to being assigned to it. The portion I was assigned to discuss deals with the origin and development of these so-called medical society approved plans. I will not bore you with a lot of details.

The earliest forms of voluntary medical insurance were those offered through mutual benefit associations, employee benefit associations and fraternal societies, and there

were also some religious societies.

The greatest growth of these plans occurred in the period between 1930 and 1940, particularly in California, Michigan and Western New York State. There was a great deal of interest by the medical societies and the hospital associations in these plans.

Recognizing this interest by the doctors and the hospitals, the AMA House of Delegates of 1943 created the Council on Medical Service and Public Relations, now the Council on Medical Service.

The purpose of this group was to develop and supply technical advice to those wishing to formulate programs under medical society sponsorship. The organization has been namd the Blue Shield Medical Care Plan since 1950. I think that gives you a little background on it.

The committee made a survey, and this was underwritten by the medical society and related plans, including Blue Shield and private insurance companies. It divides the report into two portions, namely, the medical society and related plans, including Blue Shield, and the private insurance companies, and this report is from states as of the end of 1955. There were 116 plans covering approximately 39 million people under the medical society and related plans including Blue Shield. There were approximately 500 private insurance programs covering approximately 56 million additional people.

There is a little notice at the bottom of the page here stating that as of 1957—and this covers over-all coverage by insurance of our population—hospitalization 123 million, surgical expense 109 million, medical expense 74 million, major medical and hospital 13 million. It seems to me that is a pretty wide coverage of approximately 180 million people.

The next topic was basic and major hospital, medical and expense benefits.

The most prevalent type of health care is

either indemnity or service.

The recently introduced contract for health care protection is called major hospital and medical insurance, and in those come the large aggregate sums of \$5000, \$10,000, \$15,000 which usually carry some self-insurance or deductible provision.

It says, "The application of deduction for co-insurance as well as inclusion for certain benefits is to control utilization in premium

cost.

The conclusions of the survey are that they approve of both the medical society-sponsored plans and also the private insurance plans. The effect of these plans on the quality and quantity of medical care is that we assist these plans that provide financial assistance to the insured rather than medical care itself. They do not appear to have a direct effect on the quality of care. While we realize that it has its effect on increased demand for treatment, we cannot measure that effect.

As to the legal and ethical status of the arrangements used, their conclusion was that

it was legal and ethical.

What effect, if any, do these plans have on the traditional patient-physician relationship? Their conclusion on that was that it has none.

It says, "The extent to which any insurance program influences any patient-physician relationship can be gauged primarily by the extent to which insurance limits treatment or limits choice of physician."

The committee went on to state that it is of the opinion that classification of professional services as hospital service is improper

and not to the public interest.

They encourage cooperation between the physicians and both the medical-society-sponsored plans and the private insurance program.

PRESIDENT BAKER: Do I hear a motion that it be accepted?

DR. BRIDGER: I so move.

(The motion was seconded, was put to a vote and carried.)

PRESIDENT BAKER: The next one is for Harry Johnson. This is on the AMA Commission on Medical Care Plans. This is on Occupational Health.

DR. HARRY JOHNSON: In 1933 the House of Delegates adopted a sort of code of ethics which was brought forth by the Lake County, Indiana, Society, and we in

this Society in 1949 adopted our own interpretation of that. That stayed in effect until 1958 when we presented this in our report, and it was accepted and adopted by the House of Delegates: "Objective and Functions of Occupation Health Programs."

This covers pretty much the idea and the ethics that we would like for the industrial surgeons to follow in conducting health programs for employment. Perhaps I should go back and tell you that I think it was in 1954 that the Governor let it be known in a press conference that he was interested in securing more industry for the State of North Carolina. Following that, after expressing his interest in that, our committee got together and asked the Governor to help us. We had been trying to interest physicians in the state in equipping themselves to do a better job for industry, and we felt as if we were not getting along so well so we asked the Governor to appoint a council. He did so, and, in cooperation with members of the Medical Society of the State and our Committee on Occupational Health, we have held three Governor's Conferences, I believe, and at Chapel Hill each year for five years we have had a symposium on occupational health. Last year we had Dr. Dixon Holland, the Secretary of the Council of the AMA. down to talk to us, and he outlined the things in here quite emphatically. I hope you have all had an opportunity to read it.

There has been some opposition to the idea of industry employing a specific surgeon or a specific physician to look after their employees. If that is handled right and it is handled according to the rules and regulations or suggestions laid down in this outline of scope and objectives here there will not be any room for complaints.

We have statistics from a number of industrial surgeons in the state and elsewhere who are going by the rules, and it means more practice for the local physicians—if you want to put it in a matter of dollars and cents—for the doctors in the community and for the surgeons and all the specialists than they would get otherwise.

In the matter of pre-employment examinations and interval examinations, hernia, and numerous physical ailments are picked up, and it being the duty of the industrial surgeon to examine the patient and when he finds something wrong refer it to the patient's attending physician, unless it is a headache or something like that that he needs to take care of to keep the man on the job that day.

That is about the gist of the report. We approved it and recommended it to the

House of Delegates last year, and it was approved by them, was published in the July 6, 1957 Journal of the AMA, and copies of it are available through the offices of the AMA. If any of you are interested or anybody comes to you with any questions, refer them to this published source. If the industrial surgeon keeps proper liaison with the physicians in the community we will not have much trouble about it.

PRESIDENT BAKER: Do I hear a motion that the report be accepted?

DR. PASCHAL: I so move.

(The motion was seconded, was put to a vote and was carried.)

MR. BARNES: There was another segment that had to do with health services in the colleges, and that was referred to Dr. Combs because it was not a proper matter for this committee to consider. Dr. Combs is going to submit a written report. I don't believe it has come in as yet, has it?

PRESIDENT BAKER: I have not had anything from Dr. Combs whether the college health programs are giving us any

trouble.

MR. BARNES: There has been no difficulty in this state except that reported in Pitt County about two years ago, and I think that was readily adjusted when it was known by the college officials that their mode of operating out-student health services did not meet medical concepts in that community. There have been no further representations of problems since that time. (This concludes Analytics of AMA Report on Medical Care Plans.)

PRESIDENT BAKER: Next is the Committee on Radiation, and I will give that

report for Dr. Reeves.

As you know, a Committee on Radiation has been set up by the Governor in appoint-

ing a committee of 33 people.

Wm. D. Carmichael, Durham, is chairman of this and as far as I was concerned it seemed to me it did not give any authority to medicine and to the State Board of Health as the legislative bill was originally written.

We had all of the deans of our medical schools on it. We had Dr. Duck, Dr. Paul Gross, who is a scientist, as you know, and Dr. Robert Reeves represent the State Society on it.

As I see it, the law is perfectly acceptable

I don't think we need any action on this. It is just given for information.

Next is the report on Constitution and By-

Laws.

I am sorry to tell you Dr. Roscoe McMillan had both legs broken. He is out on crutches.

I am also sorry to report that another ex-President, Dr. Street Brewer, has had a fractured dislocation of his ankle and has

fractured the astragalus.

Dr. Hubert Poteat, Jr., is now back in the room. Dr. Poteat, we will get your report on the Legislative Committee. Before you make it, I want to tell you that we made some very complimentary remarks about the work you have done, and I want to thank you again. It has been excellent.

DR. POTEAT: Thank you, Mr. President. This has been one of the most interesting springs I have ever spent. I have been very much impressed with the sincerity and honest interest of a large number of the members

of the current legislature.

It was with considerable apprehension that I appeared at the first of a number of public hearings which we have attended, but the cordiality that I was shown and the acceptance of our recommendations was very stim-

Copies of the address that Dr. Baker made at Pinehurst in January were sent to all members of the General Assembly and to most of the members of the Congress, and Dr. Edgar Beddingfield and I received, I think, a letter from every member of the General Assembly expressing appreciation for having seen these remarks and volunteering help and showing interest in matters pertaining to the field of medicine. The same is true of the Congress.

John Anderson I am sure will agree that in this session of the legislature when a matter comes up having to do with public health, private practice of medicine or anything else, instead of going ahead and doing something, these fellows say, "Lets wait and see what the Medical Society thinks about this." So we have very good rapport in the legislature, and I think it is to the credit of organized medicine that we do.

I would give counsel on one point to whoever is my successor as chairman of this committee, and that is not to overdo it up there. Those fellows have to listen to a whole lot of yammering. Be as brief as you can be when you present an issue and make an appeal on an issue, the shorter you make it I think the better off you will be. Also don't be up there too often trying to tell them all their business.

My report is in this brochure. I won't go into it in detail except to report one or two

things that have been accomplished.

The polio vaccination bill, as you know from the press, was introduced and has been passed and is now enacted into law. We got a marvelous break in the public hearing on that bill. Only one man arose in opposition to it, and nobody knew who he was. Afterwards we came to find out that he was a chiropractor so we have had a hammer and we have used it with good effect.

The Blood-Alcohol Determination—actually a urine, breath or blood test—has been side-tracked and apparently will be defeated. Dr. Forbus of Duke and the physiologist from the University of North Carolina and Dr. Wolfe made, I think, the finest appearance that I have ever seen before a legislative committee. They really laid it on the line. There it was. They had all the questions answered. There was no problem about it at all. My part in it was very simple, to say that the Medical Society of the State of North Carolina endorsed it.

I understand that Dr. Robert Reeves is not here. With reference to the radiation bill, that matter was handled by Dr. Reeves and Dr. Baker with very little effort on the part of the Legislative Committee.

The sterilization bill—it was with considerable reluctance and some embarrassment that I appeared at the public hearing on the sterilization bill.

You were polled by mail, and some 12 out of 17, or some such figure as that, voted to endorse it. I made as innocuous an appearance before the committee as I could make. They have another sterilization proposal, one that they are going to handle through the Solicitor's office in the local counties.

The osteopaths got one in up there that had to do with the internal affairs of the Osteopathic Society, the increase of their registration fee and one or two other matters. It is a bad bill, but it apparently had to do only with them, so we made no public presentation about it. It was palatable.

There are two matters still pending. One has to do with the subsidization for nurses. Dr. Brockmann and his committee have done a tremendous job on this. I met with them and the Hospital Association and hospital administrators on two different occasions.

They developed a bill that each year of the Biennium \$200,000 would be available for scholarship nurses and \$200,000 for hospitals running schools for nurses.

We are going to try to see this thing through. How much they will give or what

they will do nobody knows.

Dr. Brockmann and the Committee on Nurses have done a tremendous job as did Dr. Sam Ravenel in the polio business.

There is another bill which has come to our attention. It has come in, in the last 72 hours, and actually I have not had much opportunity to look into it or discuss it with our attorney, Mr. John Anderson. It has to do with the method of collecting fees in Workmen's Compensation cases where tortfeazor actions culminate in awards which make proper coverage for medical costs possible.

May I express the appreciation of the Legislative Committee first to Dr. Baker who has been very active in this matter and has directed our thoughts and actions to the nth degree, and I also wish to thank Mr. Barnes and Mr. Anderson. I think the Medical Society of the State of North Carolina is indeed fortunate to have men of such character to represent us.

If there are no questions, Mr. President,

that is my report.

PRESIDENT BAKER: Thank you, Hubert.

We will hear now from Dr. Rousseau's report on National Legislative Action.

DR. ROUSSEAU: Before you do that, I move the adoption of Dr. Poteat's report.

(The motion was seconded, was put to a vote and carried.)

PRESIDENT BAKER: Dr. Rousseau, I would like to say right now before you start to present your report that I think you have been rendering a most valuable service. Outside of our obligation as doctors and physicians to eradicate disease when possible and cure disease, I think Dr. Rousseau is about to follow Dr. Poteat with a report that next to these two things is the very life blood, one of the most important things facing medicine today, and that is national legislation.

DR. ROUSSEAU: There is a lot going on in the Federal Government, particularly in this 86th Congress. There have already been about 100 bills introducd to change the Social Security Act. They include many medical aspects.

I think we should as physicians support some of these things in Congress. There are three or four which I would like to mention first that I think doctors ought to support.

Congressmen like to hear us support something. I had a letter from Senator Byrd not long ago. It was in response to a letter I wrote to him in which I commended him on his strong stand on civil and states' rights. I did not mention any other legislation.

His response was to this effect: "I am the most amazed person in the world to have a letter from a doctor complimenting somebody and not opposing socialized medicine."

The AMA, I think with the toxicologists and the druggists, have worked out a bill on hazardous toxic substances. It requires that toxic material, explosives that are dangerous,

poisons, be labeled by the manufacturer, and that this label be put on the outside of the package before it is shipped to another state.

Another thing that it talks about is intlammables and things that generate personal injury or illness. It must be written on the outside of the package as to what the first aid treatment is, the antidote for the poison, and say that it should be put out of the reach of children. I think we ought to write our congressmen about that.

I think we ought to oppose the bill that is introduced to permit foreign children, orphans, to come to this country with tuberculosis and other severe communicable diseases. The AMA took the position that they should be treated at the port of entry. Personally, I would say treat them at the port of emberkation. We don't want them over here if we have to take care of them as fulminators of infectious disease contracted elsewhere. We don't want them spreading disease around. It is going to be very expensive taxwise to bring them to this country.

There is another bill introduced to change the Social Security Act to provide that an individual's entitlement to children's survivors benefits shall continue after he attains age 18 for so long as he is regularly attending school. It has been said by some that some of these boys and girls would stay in school for the rest of their lives if this bill went through. (I am not going to tell you who said that.)

Probably the worst bill and the greatest threat to medicine and also the greatest threat to the high standard of medical care is the Forand Bill which provides for free hospital care, surgical care, to all beneficiaries of Social Security.

There is another bill to amend Social Security by Franklin D. Roosevelt's son, James Roosevelt of California. It is to raise the tax base on Social Security this year to \$10,000. Actuarial or insurance statistics have predicted that if this were to go through by the year 2000 the tax base on Social Security would be \$20,000 and that the tax is going to be around 18 or 20 per cent counting employer and employee both. That is just the way it is headed up there in considering social security.

Then there is Dingle, the son of the old Murray-Wagner-Dingle crowd, who has introduced a bill on Social Security to give free medical care to everybody; in other words it provides for complete socialization of medicine. That won't get anywhere in this Congress, but when it gets hot I certainly think we ought to get busy on it.

There are other bills, and AMA doesn't

think any of these other radical bills will be passed until the Forand Bill is passed. It is being discussed now in the Ways and Means Committee. I don't think thy have set dates for hearings yet. (Note: These cul-

minated July 13, 1959. Ed.)

The other bill, of course, which we should write about is the Keogh-Simpson Bill. The bill passed the House in February by an Only 30 voted overwhelming majority. against it, and the House was full. That ought to raise some influence on the Senate. It is now in the Senate Finance Committee, and we ought all to write Senator Byrd, the Chairman of the Senate Finance Committee, and give him good reasons why this bill should be passed, to get rid of tax inequity, tax discrimination, against the self-employed. Businessmen and other employees have been allowed to do what this bill provides, namely, put away a certain amount of money in a trust fund from which you get it back, and it will be tax-exempt until you begin to take it down at your retirement age, and it is at that time that you begin to pay income tax on it.

I understand that last year Senator Byrd was in favor of this bill, but he said that the Ways and Means Committee gave it to him only on the last day of the session of Congress, and he did not have time to study it.

Byrd is tax wise, and he wants the budget balanced, and the Treasury has told him they could not afford to lose the high income tax that the self-employed are now paying and wait to get it back until they retire. That is the Treasury's position. I don't know what Byrd is going to do with this bill, but we just have to watch it because it is certainly time that this bill be passed for the self-employed.

DR. ROUSSEAU: May I make one comment about the State Legislature. Some time early last fall our district solicitor in Winston-Salem asked me to talk to the Grand Jury about the Naturopaths. I did go and talk to the Grand Jury for about an hour. We have had two abortions attributable to them proven and two deaths in the past year or two years.

Now Harvey Lupton is getting worried about it, so he talked to Judge Olive, and Judge Olive said it would be a fine thing if we talked to the Grand Jury and got their

recommendations.

The Grand Jury voted unanimously to ask Judge Olive to recommend that legislators introduce some bill to stop Naturopaths in this state. Judge Olive made such a recommendation. Mr. Gobble, our Representative,

has been talking about introducing this bill, but I think there has been some difference of view expressed by John Anderson and some from the AMA to the bill. Maybe you want to discuss that after I am out. You won't have time now, I expect. I think they should give their reasons for it. Judge Olive simply recommended that it be an Act saying that it is unlawful for a Naturopath to practice any of the healing arts in the State of North Carolina.

I talked to Mr. Lupton again yesterday, and he said the better way to do this thing would be just to make an amendment to the Medical Practice Act saying that for anybody to practice any of the healing arts in North Carolina they must have an M.D.

certificate.

DR. POTEAT: The problem that we have had with this thing, Dr. Rousseau, has been in the matter of defining what Naturopathy is. I don't know what it is myself and there is concern that to define it in prohibitive statute might give it status for support in later acts or interpretations.

DR. ROUSSEAU: If necessary we can find some definition for it. I would rather do anything than have these Naturopaths

still killing our people.

DR. POTEAT: Before we have it introduced we have got to be able to tell them whom we are talking about.

DR. ROUSSEAU: I wanted to say where that originated. It originated in the Grand Jury.

There are a lot of other things going on, but there is nothing else imperative.

MR. BARNES: I would like to say in this discussion on the Naturopathic problem, that in the State of Tennessee and in the State of South Carolina and I believe in the State of Florida, the Naturopath some time in prior years was able to get the general assemblies of those states to enact a Naturopathic Act, defining and providing for a system of healing in those states. Those three states have rescinded those laws or repealed those laws, and in the repealing law they made the practice of Naturopathy in those respective states a criminal offense; so, having been defined in one law and then repealed, they had something to go on.

AMA says—there happened to be a field counselor in our office the day I was trying to get some information from South Carolina on it, and he said there was some interest in AMA on that subject. He went back and consulted with Mr. Joseph Stetler and Ed Holman of the legal staff. He wrote back that you had no system of healing under the system of Naturopathy in any

state and they thought it was unwise to make a prohibitory act. I don't know enough law to know what they are talking about. That is in substance what they said from AMA.

PRESIDENT BAKER: Do I hear a motion that we accept Dr. Rousseau's report?

DR. SAMS: I so move.

(The motion was seconded, was put to a vote and carried.)

(There was discussion off the record.)

MR. BARNES: I have a letter from Dr. Roscoe McMillan stating that he cannot arrive until tomorrow and asking that this report be made to the Council for him on the Constitution and By-Laws.

PRESIDENT BAKER: John Anderson,

will you give it?

MR. ANDERSON: This is a report as it is going to be to the House of Delegates. I

will summarize it very quickly.

We have to ratify for final action the constitutional definition of life members which you are all familiar with. That is already passed.

There is one section here that uses the word "active" membership in the definition of life members. "Active" Member should be changed to "Continuous" Member because there is no such thing as an Active Member any more. It is just a Member or a Scientific Member.

The next is to the effect that the Vice Councilor should be made an elective officer so that he would succeed to the office of Councilor on the disability of the Councilor by designation. There is a proposal to amend Article VIII to change and make such clarification. It is by a simple little change so that the Vice Councilor will succeed to the duties of the Councilor. There is no such provision in the present Constitution.

"The Executive Council having expressed the sense that Intern-Resident Members, who, before entering practice following graduation from medical school, should pay a due equal to a Student Member, recommend amending Article IV, Section 7 of the Constitution to so reduce the due.

MR. ANDERSON: There is another provision to permit the Executive Council to exempt from the payment of dues and assessments any member who in its opinion should be relieved of such payment by reason of his personal circumstances. It is just up for ratification now.

The other provisions are with regard to the Chatham County Medical Society moving from one district to another; to add the words "Grievances and Negotiations" to certain committees which are appointed by the President: to require that the local officers be elected at or before their annual meeting in November of the local societies rather than December; and that the Scientific Member Section be amended to insert in the provision saying that only white physicians may be admitted, after the word "white" "and American Indian."

DR. AMOS JOHNSON: I move that Chapter XV, Section 5 amendment be referred to a committee consisting of the President, the Secretary, the Counsel and the Executive Director to confer with the Committee on Constitution and By-Laws for proper drafting and presentation to House of Delegates.

(The motion was seconded, was put to a

vote and carried.)

MR. ANDERSON: The next proposal is to add the following to Chapter XII, Section 1. "; provided, that the dues of Affiliate Members and Scientific Members shall be 1½ of the prevailing rate of dues for Active Members and; provided, further that the dues of Intern-Resident Members shall be \$10 or less amount to be fixed by the Executive Council for physicians continuing education into intern-resident training after graduation from medical school." That is a new proposal.

That is to permit the physician who goes back into training to pay the \$10 dues or

less as fixed by the Council.

PRESIDENT BAKER: Is that clear to everyone? Do I have a motion that we approve it?

DR. AMOS JOHNSON: I move that it be

approved.

(The motion was seconded by Dr. Schoenheit, was put to a vote and carried.)

MR. ANDERSON: There is another proposal as follows: "It shall be the duty of the Committee on Arrangments to establish with the approval of the Executive Council a time and place during one of the three General Sessions or the Banquet Session at which the President-Elect shall be installed as President or other officers of the Society may be installed.

DR. BEDDINGFIELD: I move that it be approved.

(The motion was seconded, was put to a vote and carried.)

MR. ANDERSON: The next proposal is a technical amendment to add the words "a Committee on Grievances" to make the wording of Chapter X correct. It is purely technical.

DR. BEDDINGFIELD: I move its approval.

(The motion was seconded, was put to a vote and carried.)

PRESIDENT BAKER: Thank you so

much, John.

The next thing is the Report of the Executive Committee to the House of Delegates. You read it before you came here, and Mr. Barnes spoke of it earlier. I am sure you don't want me to read 17 pages. I will accept a motion that it will be accepted.

DR. SAMS: I move that it be accepted. (The motion was seconded, was put to a

vote and carried.)

PRESIDENT BAKER: There are some people who want to get away. The next is Item 11(g) Dr. Brockmann's correspondence re Blue Print Committee for Test Pool Questions for Nurses seeking licensure.

DR. BROCKMANN: This pertains, of course, to nurse education, as to education

and licensure.

At that splendid meeting which Dr. Beddingfield had down at Pinehurst in January, it was presented to the Council, and the Council approved the resolution to be sent on to the trustees of the AMA. That was done. The resolution is brief. I think it would be well to read it:

Whereas, All physicians are properly concerned with the quality, scope and availability of nursing services, and

Whereas, Such services are dependent upon the performance of Schools of Nursing and upon the action of examining boards which license these graduates, and

Whereas, A considerable amount of instruction given to nursing students is provided by members of the medical pro-

fession, and

Whereas, In spite of this medical participation, the body of knowledge considered necessary to pass a licensing examination and become a registered nurse is determined solely by nurses in secret session of a select group known as the Blueprint Committee for State Board Test Pool Examinations, and

Whereas, Although each state may determine the passing score required of its candidates on such Test Pool Examinations, the practical necessities of interstate reciprocity create a national standard unrelated to local problems of the various

states, therefore be it

RESOLVED, That the Physicians' Committee on Nursing of the North Carolina State Medical Society recommend to the Executive Council of said society that the officers of the American Medical Association be petitioned to assume a participating role in nursing education in general

and, more specifically, to immediately seek representation on the Blueprint Committee for State Board Test Pool Examinations of the National League for Nursing for the purpose of participating in the creation of the standards by which graduates of Schools of Nursing are judged for licensure and are thereby added to the limited reservoir of individuals rendering professional nursing service in this country.

That resolution went through channels and was sent to the trustees of the American

Medical Association.

From what I can gather it was referred to the National Commission for the Improvement of Patient Care. It so happens that Dr. Elias Faison was recently appointed as medical representation on that National Commission for the Improvement of the Care of the Patient. He attended one meeting. At that meeting this resolution came up. I think it is very fortunate that we have a man from our State Society on that commission because there are only six doctors from throughout the United States on it. As far as I know, this is the first time we have even had a representative from this section of the country. He sat in and listened to the arguments on it, and it seems as if the others, namely, the six nurses and six hospital administrators and the other physician representatives, took a little exception to the resolution.

Dr. Faison and I had a two- or three-hour conference on it, and the reasons that were given by Dr. Faison were referred to the various members of the Nursing Committee.

Th objections arise from the following:

(1) A recognition of the rights of the nursing profession to conduct its own affairs.

- (2) A desire not to interrupt the course of improved relations which has progressed during the past five years. Much of this has been through the efforts of the Joint Commission for the Improvement for the Care of the Patient.
- (3) (a) Ambiguity in the wording of the resolution as to which "officers of the American Medical Association" be petitioned to assume a participating role in nursing education.

(3) (b) The tone of the resolution seemed to be more critical than it should be of the examining and licensing methods set up by

the nurse profession.

(4) The fact that the resolution was not approved by our State Medical Society's House of Delegates but rather by the Executive Council which may not be as representative of the will of the members of the State Society.

They are the reasons, but after referring to the various members of our committee. our committee felt that we still wanted to reword the resolution and to refer it back to the AMA Trustees so that the meeting in June could act upon it.

The position of our committee is that medicine should take the lead in all things pertaining to the health care of our patients and that nursing education is distinctly involved in that.

So we have drawn up a reworded resolution, and it was our thought if we could get the approval of the Council we could either go personally before the House of Delegates or through the report of the Council to the House of Delegates this thing could be acted on by the House of Delegates, and, with your permission. I will read this revised resolution. It carries the same effect but it is worded differently.

Whereas, The American Medical Association House of Delegates at Minneapolis in 1958 recommended that we work with nursing, hospitals and other groups to improve the quality and quantity of nursing education, and

Whereas, The primary interest of physicians in nursing is the maximum care of their patients, and

Whereas, The medical profession recognizes and is greatly appreciative of the valuable advances made in nursing education and service through the efforts of the American Nurses' Association and the National League for Nursing, and

Whereas, The quality, quantity and availability of nursing service is greatly dependent upon the performance of schools of nursing and upon the action of examining and licensing boards of nursing, and

Whereas. Historically and currently a considerable amount of instruction given to nursing students is provided by members of the medical profession, and

Whereas, Problems have arisen as to the effectiveness of the Blueprint Committee for State Board Test Pool Examinations in accomplishing its purpose toward providing maximum nursing services of quality, and

Whereas. The practical necessities of interstate reciprocity create a national standard unrelated to local problems of

various states, therefore be it

RESOLVED, That the Physicians Committee on Nursing of the Medical Society of the State of North Carolina recommend to the House of Delegates of said Society that the House of Delegates of the Ameri-

can Medical Association be petitioned to seek by friendly cooperation a more active participating role in nursing education and service in general and, more specifically at this time, to seek medical representation on the Blueprint Committee for State Board Test Pool Examinations of the National League for Nursing. Further that two such medical representatives be selected by the proper committee of the American Medical Association House of Delegates, said representatives to be doctors of medicine who are interested in and familiar with the problems and the purposes expressed above, and physicians who by character and personality are capable of mutual cordial and enthusiastic effort to provide the quality and quantity of nursing needed in this nation.

We thought that might be more acceptable to the national group, and we feel that unless medicine and the medical profession takes a leading part, an active part, in this business, we will neglect the steps that can be taken for the improvement of the care of our patients and we will be by default losing out in a sphere of influence in which we rightly expect to carry some weight.

Of course I cannot expect you men to be familiar with all the technicalities and methods of these test pool questions, but they were set up about 1949, or earlier—I think it was about 1945—by the National League for Nursing, and they are accepted and put into practice by all the 48 states and by six provinces in Canada. It would be illogical for us to try to act as an individual state and not use these methods.

Dr. Moir Martin, who is here with me, who has had much more experience with these things than I have, described the work of the Blueprint Committee for State Board Test Pool Examinations in a very good article which he presented at the last general meeting of our session last year, and that was reprinted in the July 1958 issue of the North Carolina Medical Journal. Of course, we don't think so very many doctors in the state read those things, and we want to give every bit of information that you fellows need to act on this. If you want to ask any question, Dr. Martin and I will certainly try to answer them, but we would like your backing in this step which we think very important.

PRESIDENT BAKER: Isn't there a committee within the framework of the AMA by which this could be put before the Board of Trustees and then let it come from the committee if necessary?

DR. BROCKMANN: We had supposed

that the Board of Trustees or whoever received this resolution sent it to the National Commission, that they wanted the National Joint Commission to act on it and then bring back a report, but the National Joint Commission won't meet again until September. They had a meeting in March in Chicago which Dr. Faison attended, and they will have one in September in New York. Those

meetings last for about three days.

We asked in the resolution that it be referred to the proper committee of the Trustees. It seems to me that the logical thing is to send it in its revised form right on back to the Trustees. I am sorry Dr. Faison isn't here because he could possibly tell us, but we have an acknowledgment here from Dr. Walter S. Wiggins who is Secretary of the Council on Medical Education and Hospitals of AMA. He evidently is concerned with it, and we should think that whoever receives it in AMA would be wise enough to put it before the proper committee.

DR. PASCHAL: I move that Dr. Brockmann's resolution be approved by the Council and referred back to the appropriate body of

the AMA for their consideration.

(The motion was seconded by Dr. Squires.) All in favor of the approval of this resolution say "aye"; opposed likewise. It is carried.

DR. BROCKMANN: I understand this will also be presented at the House of Dele-

gates.

PRESIDENT BAKER: Yes. Next is the report of the Treasurer, Mr. Barnes report-

MR. BARNES: This has already been put in the compilation of reports as instructed by the Executive Council, and I assume that it will not be the procedure to read it in the House of Delegates as it has been in the past.

PRESIDENT BAKER: We are in the black.

MR. BARNES: I just wanted to say roughly, for the advice of the Council, that the budget for 1958 approved in January of 1958 by this Council and subsequently approved by the House of Delegates here last May showed estimated income of \$152,000 against an authorized expenditure of \$183,-000, which was, roughly, a \$29,000 unbalanced budget when you authorized it.

We had actual income during the year of \$177,985—these are round numbers—and expenditures of \$168,536. That gives us a net

profit of \$6914.84 for the year.

The Audit Report is here substantiating that, and copies of the Audit Report have been reproduced and sent to all the delegates

of the House of Delegates in advance and will be distributed if it is in line in the House of Delegates Monday.

PRESIDENT BAKER: Do I hear a motion to approve of this report of Mr. Barnes? DR. SAMS: I move that we approve it.

(The motion was seconded by Dr. Brinn,

was put to a vote and carried.)

PRESIDENT BAKER: Now we are down to the annual reports of Councilors. I will call each to determine addition of content, otherwise than expressed in the record. Our action here is related to the report as printed in the compilation.

DR. KOONCE: In the annual reports to the House of Delegates of the Commissioners, I call on the Commissioners for a report, as I understand it. What about the individual committee reports? Will the Commissioner call on his individual committee chairman

if there is any question?

PRESIDENT BAKER: If he feels there

is any need.

MR. BARNES: I just wonder, from the standpoint of fairness and representation of fairness, as presiding officer of the House, whether you may make a statement with reference to any committee chairman that if he has anything that he wants to add to his report that is not contained in the Commissioner's report, he can be recognized. If you call for those reports, you defeat your whole purpose of efficiency in time. That was certainly Dr. Murphy's plan as a part of this new streamlining.

PRESIDENT BAKER: I think it would be nice for each Commissioner making a report to make some remark, to say something, particularly if a committee has done

some especially good work.

PRESIDENT BAKER: Donald will be the Speaker of the House, by the way, because Westbrook is not going to be here. Do you think that each one of these Commissioners should come up and say that under his Commission are the following committees, make a few remarks, and name at least the chairman of his committees, and say that as of now there are no further reports except what is already in the report?

DR. KOONCE: I don't think the Commissioner should read the whole thing.

PRESIDENT BAKER: You can do that as he comes up.

(Dr. Baker called for the 2nd District. There was no change. He called for the 3rd District.)

DR. BEDDINGFIELD: The only change is to report that Dr. Charles Parker, who is Vice Councilor, is quite ill in the hospital in Richmond and was taken suddenly ill last week.

(President Baker called for the report for 4th, 5th and 6th District in none of which there was any change. He then called for the 7th District.)

DR. SQUIRES: I have a problem for Dr. Norton in reference to a physician reporting vital statistic certificates in Rutherford County which is always late in filing its statistical report. From January 1950 to January 1959 they filed 164 certificates of which 15 were delivered on time, and the total of those that was late was 146.

I think there is a law covering this thing. He has been approachd by the president of the medical society and by the health director of the county, and I have talked to him on the phone myself. He promises he will do better. This is not included in my report because I did not get it in time.

PRESIDENT BAKER: Has it reached the point where it should go to a Grievance Committee?

DR. BEDDINGFIELD: Dr. Norton, do

you think so?

DR. J. W. ROY NORTON: As you know, in addition to being Secretary-Treasurer of the Board of Health, I am State Registrar, but it is a law births and deaths shall be reported promptly. What we are trying to is to do as we have done in this case, and it is amazing how many do come in late. I think it is very important from the standpoint of public relations of physicians with the community and with those families that these reports be sent in promptly. This man has promised to cooperate, and we have not prosecuted anybody. We hope we don't have to.

DR. KOONCE: I move that this be referred to the Grievance Committee for action.

(The motion was seconded, was put to a vote and carried.)

(President Baker called for the report of the 8th District, the 9th District and the 10th District to which there were no additions.)

PRESIDENT BAKER: We are now down

to reports of Commissions.

PRESIDENT BAKER: Dr. J. H. Shuford is recognized for his Commission report. Jake, I want to thank you, personally, for carrying one of the biggest jobs I have ever known anyone to carry in one society.

DR. SHUFORD: As Commissioner of the Advisory and Study Commission, I don't know of anything particularly that has changed the reports in the compilation except in reference to the Blue Shield Committee.

Do you wish that brought up? PRESIDENT BAKER: Yes.

DR. SHUFORD: As Commissioner of the Study and Advisory Commission, I do not believe there is any change to be noted except for the Blue Shield Committee, and I question as to whether this should be brought up now or in the Blue Shield Committee report of which I am chairman.

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PRESIDENT BAKER: What Jake is getting ready to discuss is something very important to this group. It is a lifeline, I guess, in our affairs dealing with the government and federalization. I think you are going to refer to the 65-year-old group.

DR. SHUFORD: If you will look in your compilation of reports on page 12-7 you will find the Blue Shield Committee report, and if you will look on page 3 at the bottom, the last paragraph makes the statement that the committee considered the tentative information prepared by Hospital Saving Association as to the possible raise of benefits for coverage of senior citizens.

After discussion of all ramifications, the committee deferred any specific recommendation to the House of Delegates for service benefits of reduced fees and income limits for persons 65 years and over until further consideration could be given at future meetings. Now I report further progress on that

matter.

Last night, the Blue Shield Committee met again with the specific idea in mind to present to the Council a recommendation after further discussion of the senior certificate.

If you will look on the next page, as an exhibit you will see proposed senior certificate coverage for persons aged 65 years and over, and this was prepared by Hospital Saving Administration personnel, and it concerns Blue Shield only. This does not have any connotation or reference to the Blue Cross portion. If you read there, you find that what we did was by request of the AMA and by a directive to the National Blue Shield which was handed down to the local Blue Shield agencies, our local Blue Shield agency, the Hospital Saving Association, prepared this proposed senior certificate for our consideration. It is based on covering people 65 years of age and older at reduced benefits, and it carries an income limit provision.

There is a suggested reduced benefit in order to use the surgical schedules, the so-called D schedules and other schedules that have been worked out, which are \$200 surgical schedules. We considered that taking 75 per cent of that schedule to cover all procedures covered under the surgical sched-

ule D as it exists now under the Doctor's program, would be the proper thing to do.

Medical Endorsement—for nonoperative inpatient admission \$5 first day, \$3 second through 19th day, \$2 for 20th through 30th day. These amounts were suggested by the National Blue Shield and could be extended to 120 days if necessary for a small additional rate. But it is envisioned and our recommendation covers only the 30 days.

Radiation Endorsement—cancer therapy and diagnostic x-rays. It was suggested that the radiation therapy be carried as 100 per cent of the schedule, and that also the diagnostic x-rays be as of the D schedule.

Income limits—as you will notice, they are listed \$1500 individual, \$2400 man and wife, and these are approximate maximum Social Security payments as of now. There is a special Blue Shield Program sponsored by the Medical Society of the State of North Carolina to aid and encourage voluntary health insurance for persons 65 years of age and over. Participating physicians agree to accept the scheduled allowances as full payment for persons who hold "Senior Certificate" coverage who have no additional coverage for professional services, and are within the income limits.

Age limits—65 minimum, no maximum. Underwriting, general provisions and Exclusions—these are the same as regular Blue Cross and Blue Shield coverage. We are speaking of Blue Shield now, not hospitalization at all. This is the cost for professional service, it is approximately \$2 per month per person.

The Blue Shield Committee at a meeting last night discussed this, and we have come up with a recommendation. This is an addendum to the annual report in the compilation. There were five members (a quorum) of the committee present including myself, Dr. John Hoskins, Dr. J. A. Howell, Dr. L. Klostermyer, Dr. W. C. Goley.

Also invited as guests and advisers were Dr. John S. Rhodes, Dr. John R. Kernodle, Dr. John C. Reece, Mr. James T. Barns, Mr. William N. Hilliard, and Mr. Ken Beeston, Secretary.

(1) Dr. Austin of the North Carolina State Dental Society Insurance Committee again met with the committe in regard to a Dental Rider to be sold by HSA as a part of the Blue Shield Program. Discussion of nomenclature, procedures and fees was carried out in detail. Agreement was reached on all controversial items. It is recommended that upon completion of the proposed rider that it be approved by the Executive Council and House of Dele-

gates and made available to the public.

(2) After long discussion the following recommendation regarding the Senior Certificate was adopted by a five to one majority. The opposing vote was Dr. W. Z.

Bradford, by proxy.

Recommendation: That the Senior Certificate, as outlined in the Annual Report of the Blue Shield Committe, be adopted. It also recommended that predetermination of eligibility, based on income limits, be mandatory and that participation by physicians be voluntary. The committee expressed the hope that the Senior Certificate could be included in the Doctors' Program, and the participation by physicians would include all aspects of the Doctors' Blue Shield Program.

That last expression of hope was an effort to get some thinking on the administration of these programs of additional coverage. If it were so passed it would be a lot easier to participate in all, rather than in one

or the other or in neither.

The Blue Shield Committee presents that to you for your consideration. Do you want

to dispose of that?

PRESIDENT BAKER: Do I summarize this, that this is North Carolina's Blue Shield Committee's answer to the Forand Bill in so far as you can answer it?

DR. SHUFORD: Yes. As you know, we were requested by various people and agencies to come up with a proposed solution; and this is it.

PRESIDENT BAKER: I felt that this Society has to take positive action about what we are going to do about the people over 65 years of age. If we are going to go to our congressmen and our senators with some kind of answer to the Forand Bill, and that is what they are going to ask for, we have to do something positive. Mr. Barnes and I spent a full day in the House and Congress in the offices in January discussing the faults of Forand legislation, and they said, "If this cannot be done, give us an answer."

This is our Blue Shield Committee's answer. Is there any comment or are there any

motions?

DR. SHUFORD: Will you excuse me, please. We realized that there would be opposition similar to the opposition as evidenced in the Doctors' Program by the lack of participation in the Doctors' Program.

We will try, in using this word "mandatory" if this is passed, if the Senior Certificate is implemented and placed on sales, to do our part. We have a working agreement, or at least a verbal agreement, with Hospital

Saving as to the predetermined nature of eligibility on income limit.

PRESIDENT BAKER: It will be hard. DR. SHUFORD: I know it will be hard. but at least it will be an effort to eliminate certain abuses. That is the best you can do. This will be sold probably to individuals by calling at their homes. These theoretically are people 65 years of age who are retired most of them will be-and this will have to be sold by personal solicitation. This will be different from selling group insurance at a factory. Actually, the sales representative will have some opportunity perhaps to decide in his own mind whether these people are in the environment and income bracket as we suggested.

There will be some mistakes, yes, I grant you. But that was an effort to try to answer

some of the criticism.

 $DR. \; GEDDIE:$ I think I am the one to make the motion we approve this.

(The motion was seconded by Dr. Garrison.)

PRESIDENT BAKER: Before we vote on this, I think this group of people in this room who presumably are the leaders of our Medical Society should be prepared to go before the House of Delegates as individuals in support of this committee. If we are not going to support it as individuals, I don't think we ought to sit here and give a token approval to it. It is going to need our active support on the floor of the House of Delegates, and is going to need our active support between now and then. Does everyone in here think this should have our active support, and are you going to do it willingly? If not, I think you should say it now rather than saying it out in the lobbies.

 $DR. \ WINGATE \ JOHNSON:$ Wisconsin has adopted a bill very similar to this.

PRESIDENT BAKER: If there is no other discussion, I will ask for a vote.

(The motion was put to a vote and carried unanimously.)

PRESIDENT BAKER: Next is the dental benefits which is another thing that is important.

DR. SHUFORD: I will brief you just momentarily on this. The dentists have been dissatisfied in that patients have been sold insurance in Blue Cross and Blue Shield in which they think they are entitled to dentist benefits. That is not true so far as I know. The only exception I know is the wiring of a fractured jaw. The dentists came to the North Carolina Medical Society requesting that we try to work out some agreement with

our Blue Shield representatives to develop a

dental rider. This dental rider as proposed

and as envisioned by those who know insurance is a separate and distinct rider and is, like a surgical and medical rider, separate and distinct. It will be purchased voluntarily. If Hospital Saving has a Blue Shield-Blue Cross contract with XYZ Company, they can offer them the dental rider, but they will purchase it voluntarily. This doesn't mean that they must buy. In other words, this is a voluntary thing.

So, in coordination with the Insurance Committee of the North Carolina Dental Society we've had two sessions with them. Dr. Austin of Charlotte is an orthodontist and oral surgeon and he was chairman of that committee representing the State Dental Society. They, on instructions from the Blue Shield Committee, drew up a list of procedures, nomenclatures and fees as suggested by their committee and presented them to us, and that was the original action on March 24 in Winston-Salem. I asked him to come to our meeting again last night, and, in my blunt way, the only thing I knew to do was to go down the list of pertinent procedures and say, "yes" or "no." Finally, as I have stated here, agreement was reached on controversial items, and it is recommended that upon completion of the proposed rider it be approved by the Executive Council and the House of Delegates and made available to the public. I have never had any authorization to go further than that.

PRESIDENT BAKER: Jake, actually what this does is this gives the Hospital Saving Association the privilege of drawing up a contract with the dentist similar to what they have with us. I think they are our friends, and we would want it for them. Is

there any discussion?

DR. SAMS: I move that we adopt the report.

(The motion was seconded by Dr. Bell, was put to a vote and carried.)

PRESIDENT BAKER: Next is the Professional Service Commission.

DR. PASCHAL: I am here. I have nothing to report other than what is reported in the compilation. I will be glad to speak on any part of it you care to have spoken about.

PRESIDENT BAKER: Does anyone have any questions to ask?

Next is the Public Relations Commission by Dr. Edgar Beddingfield.

 $DR.\ BEDDINGFIELD\colon \ \mathrm{Mr.\ President.}$

My report is not in the compilation. It is complete but has not been reproduced.

It is innocuous, a summary of committee activities. There is one item that I think should be brought to the attention of the Council, and that has to do with the Committee on Liaison to the Insurance Industry. At the direction of the President and Executive Council of the State Medical Society the Commissioner was authorized to form such a committee to function as an ad hoc committee during the 1958-59 Society year. This organization was carried out, and an initial meeting was held in Greensboro with representatives of the Health Insurance Council and the North Carolina Medical Society com-

mittee in January of 1959.

It seemed to me, in meeting with insurance people—and Dr. Frank W. Jones has been elected medical chairman of this liaison committee with the insurance industry—that the insurance people are really eager to give us what we want and what the patient wants in the way of health insurance. They are eager to police themselves, to clean house, to make changes, to have clear-cut definitions of pre-existing conditions, and so forth. I think they are a good group to work with. I think it is a continuing problem, and I recommend that they be given permanent committee status.

PRESIDENT BAKER: This report has not been published yet, but I thought enough of this report so that I wrote an editorial on your President's page and commented on the fact that here are our friends who may go out of business as a result of all this. These insurance companies are much more interested in the prospect of federalization of medicine than we can even dream of being. It is true that we are trying to cut down on committees, and we do have an Insurance Committee involving membership coverage which is a little different.

DR. BELL: I move that this be made a

continuing committee.

(The motion was seconded by Dr. Amos

PRESIDENT BAKER: That is a committee under the Professional Service Commission.

Thank you again, Ed, for a great job, and thank you for the job you did in Janu-

ary in Pinehurst.

MR. BARNES: Mr. Chairman, I just wonder if the staff would be permitted today and tomorrow, since this is a four-page report, to cut the stencils on Report of Public Relations Commission and produce it in quantity enough for each member of the House of Delegates to have it in his kit Monday morning.

(The suggestion was agreed to.)

Next is the report of the Public Service Commission by Dr. Kernodle.

DR. KERNODLE: Dr. Baker and Members of the Council: I will not attempt to

read this. There are a couple of things I would like to point out. One is that under the Anesthesia Study Committee they have been working for five years, which they feel that it should be reported in the State Medical Journal. Because of that he wants the medical profession to realize that there are some problems at hand and back him and his committee when he comes with this report.

It is in the compilation for the House of Delegates or in the Supplementary Advisory and Study Commission group report.

DR. KERNODLE: The other thing I wanted to bring to your attention is that report 11-6H. It is from the Committee on Industrial Health.

There is going to be an AMA Annual Congress in 1960 in Charlotte, and he wanted full cooperation from the Medical Society public relations-wise as well as the standpoint of attendance.

PRESIDENT BAKER: Mr. Hilliard can well call that to your attention for publicity

purposes. *MR. BARNES:* Dr. Johnson, in the event that this Congress comes to Charlotte, as I understand it will in 1960, if this Society does what Georgia did and what every other state that has entertained this Congress did, although it is an AMA meeting, there are some obligations for entertainment in connection with certain phases of the program.

I just wonder if that can be brought to the attention of the Finance Committee by the fall so that this Council will have a

chance to act on it.

DR. HARRY JOHNSON: This meeting in Charlotte in 1960 would not be held until October 1960 so there would be another annual meeting before that comes up.

MR. BARNES: But from the budget standpoint it would have to be contemplated

in September of this year.

DR. HARRY JOHNSON: They have been holding the Congress previously in late January or February, and they have decided to change to October. The date is not definite, but it will probably be the 11th, 12th and 13th of October, 1960.

PRESIDENT BAKER: Is this the same committee that was held in Milwaukee last

year?

DR. HARRY JOHNSON: Yes.

PRESIDENT BAKER: It should be pointed out to you people that this thing will be attended by some people that you might refer to as big operators in this industrial world.

DR. KERNODLE: The next thing I wanted to bring up is the report of the Committee on Veterans Affairs, Dr. Elfmon

requested that we take action at the Executive Council and also in the House of Delegates in regard to the action of his committee. There has been some discussion about discontinuing the Home Town Medical Care of Veterans Program and more especially of the Intermediary System in which a committee has authority to inspect the reports and inspect the claims for dispensation, and so forth. The Veterans Administration has requested that these Intermediary Plans be dispensed with, and because of this the Committee on Veterans Affairs of North Carolina has refused to accept the proposed contract. The contract will expire June 30, 1959 unless some changes are made, and he asks that we give him support on this.

DR. KOONCE: I move that he be given

the support of the Society.

(The motion was seconded by Dr. Sams.) *PRESIDENT BAKER*: I wonder if this House is familiar with the seriousness of what is going on in Sam Elfmon's committee. He is making a tremendous fight. The AMA have been down there. There are only six states using this Intermediary System, and apparently the Veterans Administration is trying to kill it, and Sam is for retaining it. I think he has had some difficulty in the Winston-Salem regional office, and he is still having difficulty.

DR. KERNODLE: The Intermediary System is administered through the Hospital Saving for payments, and because of that the Veterans Administration wants to change that and pay directly from the Winston-Salem office. That is the substance of the whole program, keeping it under Hospital Saving where we as doctors in North Carolina have some say-so over the medical service aspects of it and some ability to inspect what is going on financially in adjustments.

The AMA Committee adopted our policy in North Carolina and they are in favor of every Society doing that, but they have not been able to gather enough strength and defense in states to gain favor from the Veter-

ans Administration.

PRESIDENT BAKER: Sam feels that as they ease these programs such as we have out of the picture they will start easing out the Home Town Medical Care altogether, and it won't be long before any veteran will have no choice of physicians but Veteran Administration Staff.

I don't know what the North Carolina Medical Society can do about it, how much more effective we can fight about it. I don't think this body, however, should fail to be aware of the fact that this may be another break-through. They broke through

in Medicare, and this may be another breakthrough where another segment of recipients is not having freedom of choice, and there are 21 million or 22 million of them.

SECRETARY RHODES: Dr. Baker, I had a conversation just a few days ago with somebody in the Veterans' office in Winston-Salem, and the contention he brought up to me was that it costs them \$20,000 a year to operate through the Hospital Saving, and they think they can save that money because they have personnel to do it in their own office, and that is what they are aiming at.

DR. KOONCE: It was about eight or nine states a while ago. Of course, they have a very appealing idea, that they are saving the taxpayer money when they do that, but they are obviating as all people in the medical profession know by generating other and useless expenses while developing a system.

PRESIDENT BAKER: They immediately increase the money appropriated to take

care of their own work.

DR. KERNODLE: They admit they will increase their personnel in Winston-Salem to take care of what now goes on in Hospital Saving at Chapel Hill.

PRESIDENT BAKER: Do we have a motion that Dr. Elfmon's request for recom-

mended action be acted on favorably?

DR. SAMS: I so move.

(The motion was seconded.)

PRESIDENT BAKER: Maybe this thing should come up before the House of Delegates.

DR. KERNODLE: I specifically asked

him to bring that up.

(The motion was put to a vote and car-

ried.)

DR. KERNODLE: It is the request of this committee also that this particular committee be changed from the Public Service Commission over into the Commission on Advisory Study in view of the fact that it is slightly unrelated to Public Service.

PRESIDENT BAKER: I think your President has a right to put those things under the Commissions where he sees fit, doesn't he? You will have to take that up

with him.

DR. KERNODLE: I would like to emphasize the last sentence of my report which says that all committees and the Commission should formulate a budget as early as possible and also have an early called meeting to organize and project their programs for the year. Thank you!

PRESIDENT BAKER: Thank you! That takes care of the Public Service Commission

report.

Does Medicare Committee for Military Dependents have anything to report? I am not sure we all know what has happened to Medicare. Chairman Dave Cogdell is full of hard fight. They gave a program to us as if these boys in the service were going to have a choice of physicians.

DR. DAVE COGDELL: I was asked to write a letter to General Wergeland condemning the hardships it is bringing on the dependents in this State. He indicated that he was going to write to Congress, and in what he had written he had said the same thing I was trying to say in my letter to him.

PRESIDENT BAKER: Is there a supplement here on the Report of Negotiations?

DR. AMOS JOHNSON: There are just one or two matters which have come up since the report in your compilations that I do not propose to bring before the House of Delegates unless you think it is advisable that we do so this year. But since this Council is authorized to support, to advise with, and to control the Negotiations Committee between meetings of the House of Delegates, I thought I would bring this up and get your approval on what we are doing, or what we are about to do, within the next year so that we might proceed with this and bring it in the report next year.

One thing unrelated to this I do want to

bring up here.

If all of you have read the report of the Committee on Hospital and Professional Relations in Liaison with the North Carolina Hospital Association you will note that in January or February they had a meeting with a group from the Hospital Association, and that meeting had not one member present to represent the Hospital Association. The only person who was present was their Executive Secretary to apologize for the one man who said he would come.

When we were setting up at a later date the Negotiations Committee, a meeting with this group from the Hospital Association, Dr. Cadmus, the administrator of the North Carolina Memorial Hospital, being the chairman, we made it very evident and obvious in the letter which we wrote them that we were cognizant of the fact that they had not fulfilled their agreement to meet with another committee, and we asked specifically whether they were going to be there.

In discussion with them during the night, Dr. Cadmus brought up without specific reference to any other committee of this Medical Society the fact that his committee did not have time and did not intend meeting with

all committees of the Medical Society. I did not specifically ask him if he meant to say that they would not meet any more with the standing committee of the State Medical Society which Dr. Mees heads but I inferred that. It occurs to me that might be a matter of exploration to find out if that is their intention, and if so, to see if anything can be done about it, because I think there is a definite place in this Society for them to meet, and I don't think it all comes under the jurisdiction or within the powers of the Negotiations Committee.

DR. BEDDINGFIELD: I included that in my Commission report. I just brought to mind the same thing Dr. Mees did, that the representatives of the Hospital Association

did not bring up.

I suggest that this year when the dates of the meeting are set up that a reminder letter go from the President of this Society to their President and indicate that this is the date, and you were not there last year.

DR. AMOS JOHNSON: If I interpreted what was said at our session correctly they planned not to meet with all committees that

voted to discuss matters?

MR. BARNES: We tried twice to arrange this committee meeting. The first time they rejected it because it was a Sunday meeting. The administrators were not about to meet on Sunday. The second time it turned out that other dates were set two or three days before the scheduled meeting, to which they had been given adequate notice, and something else came up in conflict. I think as a matter of fact it was a meeting of the trustees of the Hospital Saving Association, and they just didn't show up. But the President of the Association did intend to be there, and when he did not show the Executive Secretary called him by long-distance telephone. He said, "I put it on my calendar, and I plumb forgot it, and I am in another meeting and can't come now."

There we sat for an hour and three quar-

ters waiting for them.

PRESIDENT BAKER: Dr. Johnson, do you think they are trying to dodge Blue Shield-Blue Cross?

DR. AMOS JOHNSON: We have had two sessions with them now. In the first session we had with them last year we made no progress whatsoever. They evaded every issue.

This year at our session after about the first hour they did begin to mellow. This session was in March, the last week of March. I think we did accomplish something toward the latter part of that session. I think we have set up a rapport with them, and we did

discuss matters that they probably did not intend to discuss when they came there.

PRESIDENT BAKER: Do I hear a motion that Dr. Johnson be authorized to act for his own Negotiations Committee, that that committee be authorized to act to find out what it can regarding that situation.

DR. BRINN: I so move.

(The motion was seconded, was put to a

vote and carried.)

DR. AMOS JOHNSON: At the last appearance that I made before this committee asking for your approval of the projects for the Negotiations Committee you approved that we work further toward accomplishing some changes within all our insurance setup, and we have worked along that line.

We have groups within this Medical Society, namely, the roentgenologists, the pathologists, and the anesthesiologists, who are pretty well taken care of in the present structural setup of hospital administration in the payment of their services from Blue Cross-

Blue Shield.

We propose these three things that I will read to you, and we would like to get your support for a plan which we hope will ac-

complish this.

One is that professional service provided in all Blue Cross certificates should be removed therefrom and placed in Blue Shield certificates.

The second is that professional staff persons rendering professional services in hospital settings should receive payment for professional service, and that it is such doctor's obligation to dispose of such receipts as his personal obligations dictate provided this is not in a manner to permit exploitation of one service for the profit of another.

What that means simply is that these three groups shall bill for their service, and since the business offices of the Blue Cross-Blue Shield and up to now the professional policy blank provided for payment to just one source for all of the charges billed for, this means that it is probable that the roentgenologists, pathologists or anesthesiologists might do their own billing and make settlement with the hospital instead of the hospital making a direct settlement with them.

I don't think that would post any problem, and it would even be so elastic as to permit under circumstances that it still be done the same way but that the bill should show the services rendered by each of these three specialists.

The third was to allow professional services and diagnostic procedures to be done in a private physician's office without the criterion of a hospital admission to be in

effect for coverage to be applicable.

This means there are certain procedures now that are filling about 25 per cent of our hospital beds that require a patient to lose a day's work, stay a night away from home, create a room, board and laundry bill for the hospital, in order to have something done that could be equally well done, or perhaps better done, on an outpatient basis in the hospital or in the doctor's office.

We believe we have the mechanism set up. It has been done in other states. We propose to get a brief up setting out all the answers and to go before the Insurance Commissioner with such brief, so firmly grounded and with witnesses available to testify to specific instances. We propose to go there in the hope that it will go no further than the Insurance Commissioner, that he will decide it is within his prerogative to order these things done in due time. We would like to have your approval.

I will say this, that arrangements have been made for the financing of this procedure which will run into some several dollars, quite a nice sum, to be done by the specialty groups themselves and not come from the budget of the State Medical Society.

DR. GEDDIE: I move approval of all

three.

(The motion was seconded by Dr. Sams.) (The motion was put to a vote and carried.)

PRESIDENT BAKER: Next is the Grievance Committee, and I see that Dr. Schoenheit has left to go on an emergency call.

DR. KOONCE: The way that has been worked in the past two years, Mr. President, is that any complaints go to the Secretary, and if they can be handled by the Secretary and the President they are so handled. If there is any question then there will be a meeting of the Grievance Committee. There has been no meeting of the Grievance Committee since the last meeting we had here.

PRESIDENT BAKER: We are down to Miscellaneous Business. Consider establishing a rule related to scientific-award-chosen manuscripts competing for several awards.

SECRETARY JOHN RHODES: The matter came up because papers which were delivered at the last meeting were not put in the hands of the Committee on Awards in proper time. The only thing on this point in the By-Laws states that all papers read before the Society shall be its property. It says further that each paper shall be deposited with the Secretary when read and if this is not done it shall not be published.

It so happens that one of the papers did

not get into the hands of the committee until March, and the chairman of the committee was very much upset because he felt that the committee could not properly review these papers and decide upon the winning paper with papers being submitted as late as March.

Another thing that he thought embarrassed him somewhat was the paper that seemed to be the winning paper came from his own community, and he was afraid there might be some criticism because of that inasmuch as the time would not be adequate

to consider all of the papers.

We felt that in order to prevent embarrassment and to give the committee support we ought to have some sort of ruling about the submission of papers. It seems to me that this By-Law covers it actually if we could implement the By-Law. Those papers should be available and presented at the time that they were read.

PRESIDENT BAKER: If they were not presented they would not be considered. You

already have that rule.

DR. KOONCE: I move that the committee be instructed to enforce the By-Laws.

(The motion was seconded.)

MR. BARNES: Here is going to be my dilemma, and you had better do something to fix it for me. These committees of the sections are going to choose these papers. Then the man is not going to turn them in. My problem will be next fall when I get the papers. I will not have had any judging in the section as required.

PRESIDENT BAKER: Do I hear a motion that we follow the By-Laws in regard to papers; in other words, they must be turned in at the time they are read? Also do I hear a motion that no paper from any section can be considered unless it is turned in to Mr. Barnes within 60 days after the

annual meeting?

DR. KOONČE: I add that to my motion. (The amended motion was seconded, was put to a vote and carried.)

MR. BARNES: This is a letter from Dr.

Blasingame, of the AMA. He says:

At its meeting in Minneapolis, December 2-5, 1958, the House of Delegates voted to adopt resolution 14 requesting that the American Medical Association bring to the attention of the deans of medical schools and officers of medical societies the desirability of having certain general practitioners of the year as guests at meetings where students and younger physicians are present.

The House of Delegates also voted to adopt a resolution urging that constituent

associations make every effort to provide a type of membership for the armed forces, U. S. Public Health Service and the Veterans Administration physicians which will enable them to become active members of constituent associations and of the American Medical Association.

Our problem is that anyone that is working in Public Health, the armed forces or the Veterans Administration, that does not have a license to practice medicine in North Carolina is not eligible to membership under

our membership rules.

SECRETARY RHODES: The problem is the question of whether or not a doctor not licensed in North Carolina can be a member of this Society.

DR. SAMS: No, he cannot.

DR. KOONCE: That means that a man who is in the Army at Fort Bragg, if he is a serviceman, would have the privilege of becoming a member of this Society on a temporary basis.

SECRETARY RHODES: Isn't that your

interpretation, Jim?

MR. BARNES: Yes, and moreover, as I understand, any member of any of the armed forces certified by the Surgeon General to the AMA can have membership in the AMA independent of a state association. I don't see why it is necessary for them to have membership in the state association.

DR. KOONCE: I would like to make a motion, that our present standards of membership in the Medical Society of North

Carolina remain as they are.

(The motion of Dr. Koonce was seconded,

was put to a vote and carried.)

DR. AMOS JOHNSON: What will that motion do to your study as to membership to take care of our annual convention?

PRESIDENT BAKER: Is there any mem-

PRESIDENT BAKER: Is there any member of this Council on whom a meeting tomorrow morning at ten o'clock is going to work a great hardship?

DR. KOONCE: I move that we recess until ten o'clock tomorrow morning.

(The motion was seconded, was put to a vote and carried, and the meeting recessed at six-thirty o'clock.)

SUNDAY MORNING SESSION May 3, 1959

The Council reconvened at ten o'clock,

President Baker presiding.

PRESIDENT BAKER: The Secretary tells me that we have a quorum. Will the delegation from Harnett County please come up? This is Dr. Bruce Blackmon who has something to bring from Harnett County. I presume it is concerning the care of welfare

patients and medicine's responsibility and where it begins and where it ends.

DR. BLACKMON: Thank you, Dr. Baker. Harnett County has been concerned about the welfare situation in the county and in the nation for a number of years. Several years ago we were instrumental in bringing a new welfare head into our county which we thought was going to help solve our problem.

After this new welfare head came in, we found that we had not solved many of the problems. The situation was the same as it

had been.

The County Society then was instrumental in getting a physician on our local welfare board. We thought that was going to help the situation some, and the thing that developed from that was that we just had further insight into what was happening welfare-wise.

The thing that probably brought this to a head was one patient that I saw as a physician to fill out some forms to get this patient on welfare benefits. Where it says, "Can he work?" I put a question mark and recommended that he go to Memorial Hospital at Chapel Hill and get a complete physical checkup and see if the man was able to work. If he was not, then we were willing for him to go on the benefit rolls.

That was the last I saw of that until a few months later when, being a member of the welfare board I saw this name come through the file. He had been drawing checks every month for several months, I checked into it a little further and found that Dr. L. R. Doffermyre, our physician from Harnett had filled out a form on this same man, had put a question mark as to whether or not he was able to work and suggested that some further study should be done. But still he was drawing welfare benefits.

We brought it up for discussion, and it looked as if it was almost impossible to get him off the welfare rolls. We began to dig further into the situation, and as a result of that we have done a few things in Harnett County we want you to know about.

We have appointed a standing committee for a year to consider welfare problems and the welfare program of the county. I might say right here that we are not worried about Harnett County's welfare situation. If all we can do is just touch the Harnett County situation we will go home and go to work, but it is a national situation; it is one of the most malignant situations in our nation today so far as I am concerned.

After this standing committee was appointed, then we got approval from Dr. Win-

ston and from our local department of welfare to have three physicians examine every applicant that comes in for physical examination to go on the rolls.

If you will give me just one minute before you say that it should not take three doctors' time to examine them, I think I will show you where it is profitable for sound administration.

We established a rotating committee of three doctors to go once a month, every fourth Friday, on a rotating basis, to the Harnett County Health Department to examine every applicant that comes in that wants to be put on the welfare rolls.

That does two things. That keeps them as non-emergencies out of our office from then on when we are busy. If one comes in with his form to be filled out we say, "I am sorry. You just deal with the health department the fourth Friday. We don't do them here."

Second, that gives three qualified men a chance to see this patient, and then these three men can give a definite diagnosis or a definite opinion about whether or not he needs to be on welfare. It gets out of the personal relationship of the doctor and his own individual patient or a patient that is a cousin of Uncle John or somebody. We feel that relieving that pressure means a whole lot.

We took this same committee and went back into the file—and this I want you to know—and we pulled out a third of the oldest charts we had in the files and examined them. All we examined was the medical part; we did not go into anything else, just the medical forms. Out of that third, we pulled out a number that we thought should not be drawing welfare by just examining the record.

For instance, there was a woman drawing a check every month for cervical cancer since 1949. You know as well as I do she doesn't have cancer or she would be dead by now.

We pulled out a number and had those come in to be re-examined. Out of that group that came in to be re-examined we found that there were enough of them that had absolutely no reason to be on welfare, and we leaned over backwards because we didn't want any question on what we were doing. If there was a possibility that they should be left on we left them on. But we cut off 13 per cent of the entire file of what we went through. We took a third one night, another night another third, and we have a third to go. Out of all those we saw we cut off 13 per cent in Harnett County that have

been drawing welfare checks for the reason I mentioned and other reasons, just obvious mistakes.

DR. BEDDINGFIELD: Is this just paper work, or are you re-examining these peo-

ple?

DR. BLACKMON: On the first third of them we used paper work. We said, "This man doesn't have any legs, and he needs to be helped from here on," but the one that had cervical cancer since 1949, we laid that

Then we took the entire group of patients and examined them. We found one woman that had lymphogranuloma inguinale. think any physician here would say she should be on for the rest of her life. She was draining from all the shots she ever had. But in the case of those who had no excuse for being on whatsoever we cut off, and there were 13 per cent.

As for something concrete, we are presenting a resolution, if you men so desire that is the reason we want to come to you first, because if it is something that you don't approve of, we won't do it, but we wanted your approval before we went to the House of Delegates. This is the resolution we propose:

Whereas, it has been found:

That welfare patients shop around from one doctor to another in order to get welfare forms filled out to suit their demands:

That on occasions they go from 30 to 50 miles away from home to get their

physical examinations;

3. That often pressure is put on individual physicians to fill out forms in such a manner as to make it possible for patients to be put on welfare rolls, therefore, be it,

RESOLVED. That no member of the North Carolina State Medical Society shall fill out welare forms for patients outside his own county, except with a written request from a physician residing in the same county where the patient resides,

Furthermore, Be It,

RESOLVED, That it is recommended that each county medical society establish a rotating committee of not less than three physicians which shall work with the local department of public welfare and shall periodically, usually monthly, examine all applicants who require a physical examination before receiving welfare checks. Once this rotating examining committee has been established it should give the applicant the benefit of the judgment of three physicians,

Then, Be It Resolved that no physician shall examine a patient solely for welfare application other than approved by the rotating committee, except in extenuating circumstances such an invalidism or such other cases as may be approved by the rotating committee. Further Be It,

RESOLVED, That a standing committee of three from each county society be elected by each county to implement the

formulation of such a program.

It is not intended by this resolution to impose any limitation upon any person's freedom of choice of a physician for the purpose of obtaining medical treatment or advice or upon a physician's duty to make an examination for such purpose.

PRESIDENT BAKER: I am going to ask the Councilors to speak on this.

DR. GARRISON: Why not have the President appoint a subcommittee of this group to work with the gentlemen from Harnett and have something worked out before we adiourn?

PRESIDENT BAKER: I hereby appoint Dr. Garrison and Dr. Beddingfield to work

with this committee.

MR. BARNES: Last October when we announced the banquet reservations, there was a provision that there would be no cancellations after the 1st of April. We had to do that in order to set up the scheme of assignment of tables in advance that the President had recommended and the Committee on Arrangements had approved.

We have two letters. They refer to the fact that they have bought these tickets and cannot get here to the meeting, and they wanted a refund. According to the record, I am not supposed to refund.

PRESIDENT BAKER: Do I hear a motion that Mr. Barnes be allowed to refund these people the money?

DR. KOONCE: I so move.

(The motion was seconded by Dr. Sams,

was put to a vote and carried.)

MR. BARNES: Dr. Safer was invited by the Section on Surgery to present a paper before the General Session. Subsequently he has had something develop which takes him to the Far East or the Near East, and he will not be in the State at the time of our meeting next week. He has delegated a Dr. Redding to appear and read his paper in the General Session. There is a rule that there has to be permission of the Society to do that. The Chairman of the Section, Dr. Hubert Patterson I believe it is, from Chapel Hill, has recommended that this be done, and I see no reason why it should not be DR. SAMS: I move that the privilege be granted the man.

(The motion was seconded, was put to a vote and carried.)

PRESIDENT BAKER: Next is "Filler

material" on the Journal.

MR. BARNES: Some time ago Dr. Baker made some comment to me with reference to the extent of "filler material" on the Journal and the cost of it. He asked me to put it on the agenda for discussion today in the light of the total cost of the Journal.

To print it costs somewhere around \$27

a page.

PRESIDENT BAKER: We had 12 pages in our recent Journal not long ago that to me could have been deleted. I thought we should bring it up from financial considerations, that this filler material is not needed in that Journal.

I think if somebody is going to talk somewhere and it can be published a week or two beforehand that that man is going to speak, then we want to know it so if we are in that area of the state we can go and hear the lecture. That is a different thing.

DR. WINGATE JOHNSON: I agree with

you on that, Lenox.

PRESIDENT BAKER: I think all you need is the backing of the Council to edit some of this material.

DR. SCHOENHEIT: I would like to make a motion that this be left to the discretion of the editor of the Jaurnal, to delete or do as he sees fit.

(The motion was seconded by Dr. Brinn, was put to a vote and carried.)

PRESIDENT BAKER: Jesse Caldwell was here yesterday to report on this Ad Hoc Committee on a Retirement Fund for the Society.

I think I can bring it down to a few words for you. It looks as though his committee is going to be in a position if the Keogh-Simpson Bill does go through, to have two forms of participation, namely, one for the trust fund or bank for a man who already has a good endowment insurance program set up and does not need any more endowment; and where you can put his money in a trust and that can be handled with all the privileges that go along with a trust fund including investment, et cetera. The other is for the doctor who may not have a good endowment or a good insurance program and may feel the need for insurance coverage. We will try to set up a program that will cover that type of doctor.

He was going to give the pros and cons, but that is to be given in our session of Monday of the House of Delegates. Mr. William Werber, who is an insurance counsel in Washington, D. C., has written on this subject many times, helped write this bill originally, will come down and try to give us the advantages and disadvantages of the endowment insurance program, and I imagine it will be more advantageous than disadvantageous for he is an insurance counsel, not an insurance agent. Then we will have a man representing the North Carolina Bankers Association selected from their Trust Committee to come down and tell us the advantages and disadvantages of trust participation.

I hope we get information from those two men. This is all wishful thinking. The Keogh bill has not been passed.

The next item is to discuss our position on a Compulsory Social Security poll.

MR. BARNES: The AMA has requested some information from the constituent associations with reference to their point of view on Social Security for physicians. We conducted a poll for the State Society I think in 1954 or 1955 the results of which were overwhelmingly in opposition to Social Security coverage for physicians.

There has been no action of the State Society doing anything about a poll subsequent to that time, but many of the state associations at the present time are expressing in resolutions to the AMA for the June meeting their position. I simply put this on the agenda to know if there is any position you wish to take here because certain North Carolina physicians who are involved physically do express the point of view that maybe there should be a reconsideration.

PRESIDENT BAKER: Do I hear a motion as to whether we take a poll of our Society, or could we poll our House of Delegates which would be a pretty good sampling of the thinking on the part of the Society?

SECRETARY RHODES: I might say, Dr. Baker, that my own county society at its last meeting, by a very small margin—I have forgotten exactly the number—voted to support Social Security and I believe intended at least to instruct the delegation to support it. Is that right, George?

DR. PASCHAL: That was my under-

standing.

SECRETARY RHODES: It was a very

small margin vote, but it did pass.

DR. BRINN: I think this should be something decided by the membership of the Society rather than the delegates at this particular meeting. It is a question of how many delegates you are going to have and whether they represent the constituency or not.

PRESIDENT BAKER: Do you want to make a motion that we take this up with the House of Delegates in regard to having this poll? The House of Delegates will have to make the decision, I think.

DR. BONNER: I think we had better wait and see what happens to this bill.

PRESIDENT BAKER: This is all in the press already, you know, from other states.

DR. PASCHAL: I think we ought to have an expression from the membership of the Society as a whole, and I would be inclined to submit a questionnaire.

PRESIDENT BAKER: At an opportune

time, will you add that?

DR. PASCHAL: Yes, at an opportune

time.

DR. AMOS JOHNSON: Would it be improper when the poll is submitted, the individual ballot, if some committee from this Society got up a bunch of facts for and against so that some of the people who are not familiar with this proposition could be a little better informed as to the pros and cons of it?

PRESIDENT BAKER: By putting it "at an opportune time" I think we cover it.

DR. KOONCE: Would it be early to have that at the General Session, just an open vote? Would that be premature?

PRESIDENT BAKER: I don't know. I think we are fooling with something rather dangerous. We may be surprised. state societies have been surprised at the number they get.

MR. BARNES: Pennsylvania voted, I

think, two to one for it.

DR. SAMS: The druggists and the dentists were against it to start with, and they are all now for Social Security.

PRESIDENT BAKER: We have a motion before the House that has not been seconded, that we make this survey at an opportune time.

(The motion was seconded by Dr. Brinn.) (The motion was put to a vote and car-

ried.)

PRESIDENT BAKER: Next we will hear from Dr. Murphy, a report on the Davie County Memorial Hospital situation.

DR. THOMAS MURPHY: Fortunately,

everything has been settled.

PRESIDENT BAKER: The Gaston County Memorial Hospital. There has been a question there about collecting fees, et cetera. We have had correspondence from someone in the county medical society to the effect that some doctors feel that they should be privileged to use their own drugs and charge for them in the accident room of the Gaston County Memorial Hospital. I don't know whether it goes on in the service room inside the hospital. I think this is referring to the emergency room only. The hospital superintendent is of the opinion that all drugs used under the roof of that hospital should be hospital drugs and they should charge for them and use the penicillin that they have stocked. They probably have a good contract for buying penicillin.

I think this should be referred to our Com-

mittee on Hospital Relations.

DR. BEDDINGFIELD: They have already investigated it. They made the recommendation, and their recommendation is, as I recall, and I think I am right, that the hospital administration was correct, and they told the doctors to go ahead and use the hospital drugs.

PRESIDENT BAKER: Under their roof I think they ought to make the rules. There is no doubt they are right about that.

The next item on the agenda is Letter— State Board of Health-Polio. Roy Norton did not want to get private practice mixed up with the care of the indigent in this polio vaccine matter, and the Attorney General, I think, gave him a good, sensible ruling, that anyone in the health office in a state or county should pretty well know whether somebody is indigent or not. It would be rather expensive to investigate. It would cost more to investigate one case than to give five. He was to use his judgment, and in out-and-out cases he should refuse to give it. Does that meet with our approval? It was just a law interpretation, and we ought to know it. It is brought to you for information as to the interpretation.

DR. BEDDINGFIELD: County health of-

ficers should be notified of that.

PRESIDENT BAKER: They are notified. I have seen the notification. That has gone to them.

DR. NORTON: They were sent copies of the Attorney General's ruling without com-

ment.

DR. BRINN: I agree with the ruling very thoroughly, but I question whether the health officers should have the power of deciding who is indigent and who is not.

PRESIDENT BAKER: Will someone consider a motion to tell Dr. Norton the feeling of medicine about this, that we feel that they are thoroughly responsible for this, and so on. Roy, can you write a fairly strong letter to your health officers that they are not supposed to be lax in this thing at all

DR. NORTON: I will be glad to pass along any suggestion from this Council.

PRESIDENT BAKER: Those people do not work for you; they work for the county. DR. NORTON: They work under their

county board of health.

PRESIDENT BAKER: You may also send copies of that letter to the county commissioners in the counties in which they work who have to pay for this vaccine. It is a cost and they should be aware of the fact that it should not be abused by the health officers

DR. NORTON: I will be glad to pass along any suggestions you think would be

helpful.

DR. BRINN: I make such a motion.

(The motion was seconded.)
(The motion was carried.)

PRESIDENT BAKER: We will go back to the Harnett County question on welfare cases. Will the Committee please read the recommended changes?

(The changes are incorporated in the copy

heretofore expressed at page —___.)

DR. BEDDINGFIELD: The committee that went out of the room is not trying to adopt this thing as a state rule. We are saying that this is a suggested county policy for counties to be sanctioned by the House of Delegates if they pass it tomorrow.

PRESIDENT BAKER: But you are suggesting everything that is in that, aren't

you, Ed?

DR. BEDDINGFIELD: Yes.

DR. KOONCE: We have been fighting tooth and nail for years and years to preserve the freedom of choice of physicians. Although I see the point you are trying to make and I am in wholehearted accord with it, I say that if we come out publicly and in any way try to infringe on freedom of choice we are defeating everything we have fought for for years.

PRESIDENT BAKER: May I accept that as a motion, that this sentence be de-

leted?

DR. GARRISON: Let him read the whole motion. (It was read again.)

(The President left the chair to speak on this subject.)

PRESIDENT BAKER: The motive of this thing is good. I don't think any of us would question what these people are trying to do, and I think everybody agrees with them. But the way we are going about it I believe will be to our detriment.

If the medical societies of each county can set up a rotating committee that is cooperating as a service to our county and to our welfare department and to our volunteers, free medical service of the county medical society once a month, to see if these people are trying to impose on this law or faking, that is the principle of the thing, and I think that is the resolution we should pass here. When we try to set up rules and regulations that someone cannot go out of the county to get another examination, we are not standing on firm around.

standing on firm ground.

What are you going to do if they go to Bowman-Gray for a physical examination? What are we going to do with those people? Are we going to force them to go back to a doctor at home whom they don't like, by whom they have already been seen? Maybe they vote on a different ticket. I think we are making a mistake if we try to put teeth in this. I think this ought to be a medical service for which we can get credit, rather than to set up a federal rule that has already been passed.

The law doesn't even ask a doctor to express an opinion of whether a patient is disabled. All the law asks him to do is to give his physical findings and impressions, and that goes into the welfare department of the State of North Carolina and they decide whether he is disabled or not. Until we change the law in Washington, there is no need of this body trying to change the law.

DR. GARRISON: You spoke about the patient going to Bowman-Gray, going to Duke, going to the University. This is not my baby. I am asking for information. The doctor at each place sends it in, or the resident down there does. The point I am making is, who sent that patient down there, and why did he send the patient down there? Why doesn't the doctor back home get the opinion of those physicians and let the man at home fill out that report blank?

PRESIDENT BAKER: These come back from patients from 20 years before. The doctor may be dead. We cannot say that another man cannot go to another physician in this state, who is licensed to practice medicine, for an examination. If we have a doctor who is filling these things out loosely and letting them go, we should know that and notify the welfare department. We are trying to keep from being a law-making body.

(During this discussion Dr. Amos John-

son was in the chair.)

CHAIRMAN JOHNSON: Is there other discussion? Dr. Garrison, did you have some-

thing more to say?

DR. GARRISON: I still think that the doctor in the county who is familiar with the case should be the man who decides and determines whether or not the individual is disabled. I feel just as a lot of these people do, that if they are indigent they are going to the interns and residents of the hospitals who don't give a concern about welfare

money or anything else. Therefore they fill them out just to satisfy the individual and send them back home. The individual may have driven up in a Cadillac automobile, or he may have had working clothes on, but still he wants relief. That happens a lot of times. That intern doesn't know anything about the matter. Therefore the report should go to the doctor locally in the county, and he should be the man to determine whether or not the patient is indigent because of disablement.

DR. SAMS: The disability is not decided by the doctor that makes out the blank at all. He does not have anything to say about it. He puts down the findings and they are sent to Raleigh and reports are passed upon by Dr. Nelson Thompson at Raleigh. They are never passed on by the local doctor.

DR. KOONCE: I think we are playing with political dynamite. I think that a local county which wants to take any such action as this is protected and is perfectly within its rights in taking it. I think if we acknowledge this on a statewide basis we are going to open ourselves up to an enormous amount of criticism, and I for one would oppose it.

I would like to make a motion that this be received as information and left to county

prerogatives to do as they see fit.

(The motion was seconded by Dr. Sams.) *CHAIRMAN JOHNSON:* You have heard the motion that this be accepted as information and that action be left to the various counties and it be within their prerogative to take whatever action they see fit on a county level. Is there other discussion on this motion?

DR. REECE: I think we should point out that the financial status of the patient is something that the welfare department should investigate. The man may be disabled but he may be a millionaire along with it. The question of the man driving to the place in a Cadillac is something for the local welfare department, to see the man's financial resources in his county. That is not so much a responsibility of the local physician or the resident at the medical school.

CHAIRMAN JOHNSON: I would like to say one thing, not as chairman currently, but by way of personal opinion. I think there is a lot to what has been expressed in this motion, and I think it is not impossible that something could be worked out on this that we could accept on a state level but at the present time as it is submitted, is not workable and is not feasible, and I don't think that it should be by this motion considered dead. I think that with more experience and more thought over the years

possibly by another year we could come up with something that is tenable and workable. Is there any other discussion on this motion?

DR. SAMS: I think that is a good idea. I am in full sympathy with Harnett County in their effort to do this thing. I think if they go along with it for another year they will be improved on and come back to us with better information.

DR. KOONCE: Receiving this as information we are not killing it. We are not opposing it.

CHAIRMAN JOHNSON: Is there other

discussion?

(The motion was put to a vote and car-

ried.)

PRESIDENT BAKER: I make a motion that each county medical society offer to assist the welfare departments in securing physical examinations for people applying for welfare through an arrangement best suited for that county, but patterned along the line of what is being done in Harnett County.

CHAIRMAN JOHNSON: That was the motion and it has been seconded. If I understand correctly, that motion would mean that the executive officers in Raleigh would compile that information and would give some pattern as to how it has been done, what the thinking is in Harnett, and that this would be supplied to each of our component county medical societies. Is there any further discussion?

(The motion was put to a vote and carried, after which the President resumed the

chair.)

PRESIDENT BAKER: I think we go now to Unfinished Business, which is Delegate to the United States Pharmacopoeal Convention 1960. Jim, do you want me to discuss this?

MR. BARNES: It is an official United States Government Pharmacopoeal Convention.

PRESIDENT BAKER: Is there anyone here who wishes to help pay Ed Bedding-field's expenses to this convention and back?

DR. SAMS: I move we send Dr. Beddingfield and pay his expenses.

(The motion was seconded.)

PRESIDENT BAKER: Is there further discussion. I dont know whether you people know this, but Ed Beddingfield is a graduate of a school of pharmacy and that is the reason he was selected. He is a right nice boy, too. Is there any other discussion?

(The motion was put to a vote and carried.)

PRESIDENT BAKER: Here is a letter

from Medicare.

MR. BARNES: Dr. Cogdell saw this letter yesterday afternoon and read it. He said he saw nothing wrong with it. It is notice from General Wergeland, the Executive Director of the Office of Dependents of Medical Care in Washington, putting us on notice that they will anticipate sending our presently effective contract in June of next year for another period on the same basis. I think this is information.

PRESIDENT BAKER: It is received.

MR. BARNES: I think the committee is already empowered to extend that negotiation.

PRESIDENT BAKER: We have something on investments. Mr. Barnes will give

1t.

MR. BARNES: At the January meeting of the Council, Dr. Benton informed you that the Finance Committee would probably sell the bonds and proceed to a reinvestment of them. In March he gave me notice to proceed along that line, and I went to our banker who is with the First-Citizens Bank & Trust Company, and, with the auditor, evaluated the bonds we have at the present time. These bonds are in Series F, J, K, and in Treasury Notes. We find that in selling one K bond for \$5000 we will take a loss of \$165, and in the selling of the Treasury Notes, on each \$1000 note, there being four, we will take a loss of \$35.00 as compared with the cost of those bonds. We found that the most strategic time to sell these would be after May 15, so they will be sold on instruction of the Committee on Finance after May 15, and then that committee will assume the obligation of reinvesting them ,as I understand. under authority of this Council.

PRESIDENT BAKER: The next is announcements in reference to the Exhibitors'

party.

MR. BARNES: That is tomorrow afternoon at five-thirty. It is at the Asheville

Country Club.

PRESIDENT BAKER: Under New Business we are down to Expenses of James T. Barnes in attending Institute for Association Management at Northwestern University. I thought we took some action and okayed that.

MR. BARNES: No. I don't believe so. Dr. Reece thought I should go, but he thought. from the standpoint of expense, we ought to mention it here today.

DR. SAMS: I move we send Mr. Barnes and pay his expenses.

(The motion was seconded, was put to a vote and carried.)

PRESIDENT BAKER: I think we should extend our thanks.

We will have one minute on the relative

value schedule.

DR. GARRISON: In checking over these committees on relative value schedules, I find that the majority of the men, for instance, in medicine, in orthopedic, neurology, plastic surgery, radiology, obstetrics and gynecology, nose and throat, are made up entirely of specialists.

The point I am interested in is to know, first, what plans are scheduled for the general man, and, second, whether or not this year they are planning to come out with two different fee schedules, one for specialists, one for the general man. I don't see any representatives from the General Practice of Medicine on any of these committee.

PRESIDENT BAKER: I can't answer. Can someone find that committee, Jim, the Committee on Relative Values? (It was named Ad Hoc by the Commissioner on Ad-

visory and Study.)

DR. AMOS JOHNSON: There are two or three general men—Jeeter and one or two others—on there, but there is no concerted representative from the Section on General Practice. It seems to me that a committee not represented by General Practice does not put up with a dual set of fees, but that those fees that are applicable to general practitioners be the same fee for the same procedure, diagnostic procedure or whatever, whether or not it is done by anybody in this state. If we do not so do, then we are declaring that we are practicing a double standard of medicine in the State of North Carolina and that we are sanctioning two classes of medical care.

DR. BRINN: I hesitate to use the word "second class doctors" as much as "second-class citizenship" used throughout the country for a long time. But I think when we set up two fees in medicine we are setting up second-class doctors. I don't think we as doctors think too highly of that particular thing, and I make a motion that we appoint a committee to go along with this group with the idea of making the fees the same throughout.

PRESIDENT BAKER: Whether Board certified or otherwise?

DR. BRINN: Yes.

PRESIDENT BAKER: I only know of one exception where Board certification comes in, and that is for the radiologist. We fought for it like the devil in orthopedics on the x-rays. We tried to get the same fee that the Board man was getting, but we didn't get it. There is a motion on the floor

that we all stay in the same water and keep

swimming.

DR. BEDDINGFIELD: Isn't this taken care of by the fact that there is a difference in a fee schedule and a relative value schedule?

PRESIDENT BAKER: This is not a fee schedule. This is saying what you should get for an appendectomy. It gets so many points, a brain tumor so many points. This has nothing to do with specialization. This is the

procedure and not who is doing it.

DR. AMOS JOHNSON: But what his (referring to Dr. Brinn) idea expresses is that this Council go on record as approving that there be one set of fees, and one only, for physicians and doctors in North Caro-

lina.

PRESIDENT BAKER: That motion has

been made and you seconded it.

DR. PASCHAL: Dr. Brinn suggested that they appoint a committee. Is that necessary? DR. AMOS JOHNSON: I think not.

(The motion was put to a vote and carried.)

PRESIDENT BAKER: Jim has been whispering to me ever since this opened at two o'clock, "Are you going to bring up this matter of Hospital Care?"

(There was discussion off the record.)

PRESIDENT BAKER: Does anybody want to make a motion that we change our present status with Hospital Care? We gave them the proposition and they have not fol-

lowed through on it.

DR. PASCHAL: Let me speak on this Blue Shield approval for the Hospital Care Association. I am stimulated to this by virtue of the fact that a number of the doctors have made representations about it. Some are dissatisfied that the Hospital Care Association is not participating in the writing of this, and I know that we opposed it, and urged a continuation of our present status at the last meeting.

However, by way of a little background, if you will indulge me just a minute or two, I would like to make the following state-

ment:

Α

STATEMENT OF UNDERSTANDING

The Medical Society and the Blue Shield Plan, that is, the Hospital Saving Association, specifies that the four physician trustees of the Hospital Saving Association have an equal voice in the election of one-third of the Hospital Saving Association Board representing the general public.

The Hospital Care Association was approved last year as a Blue Shield Plan on

the identical basis as the Hospital Saving Association. However, the By-Laws of the Hospital Care Association provide that its four lay directors be elected by the membership of the Hospital Care Association, just what you said.

Because the method of appointing the lay directors of the Board of the Hospital Care Association is not identical with the method specified by the Statement of Understanding, Blue Shield approval for the Hospital Care Association has been delayed. Those who object to the Hospital Care Association By-Laws concerning the selection of the public representatives on its Board apparently feel that because the Blue Shield program provides service for low-income families, that the Medical Society should have greater control of the appointment of the lay directors to this Board.

There seems to be little basis for this objection since the Boards of these plans can only advise or recommend concerning the Blue Shield program.

Paragraph two of the Statement of Understanding specifically puts the control of benefits, fee schedules, and so forth, in the Blue Shield Committee of the Medical Society of the State of North Carolina.

In view of this, it would seem that the method of appointing the public Board members to the Hospital Care Association's Board would be considered acceptable. Such action would permit the approval of the Hospital Care Association as a Blue Shield Plan in accordance with the intent of the action by the Medical Society at its meeting last year.

Members of the Board of Trustees of the Hospital Care Association feel, and I understand that all feel, that in order that Hospital Care can participate in this Blue Shield program we are going to have to make a concession to let them go ahead with their present Board structure. I don't see any hope to have it done unless we do acquiesce, but I point out again that paragraph two of the Statement of Understanding which I will be glad to read if you are not familiar with it—although I think you are all familiar with it—

(In the course of this discussion the President requested Dr. Amos Johnson to assume the chair.)

PRESIDENT BAKER: Have you read

the one about the budget?

DR. PASCHAL: I have paragraph two here which spells out that the thing is in the control of the doctor, and I think that it is. They are anxious that the House of Delegates reconsider this thing, and they

would like to have the approval of the Coun-

cil in sponsoring it.

DR. KOONCE: If this simple change by the Board is so insignificant that we ought to ignore and acquiesce, why isn't it so insignificant that their Board would meet our demand? I cannot see any reason in the world why George Watts Hill should control that thing to the point where he can tell us what we can do and what we cannot do. I see no reason for acquiescing. We made a statement: I think we should stand by it.

PRESIDENT BAKER: I love your speech. I have made that speech for seven years when I was a delegate. Now I am their bitter opponent presumably in their minds. You did not read the most important thing in that Statement of Understanding that worries us. Blue Shield and Blue Cross are two separate, different items, and they collect money from different sources. But that Statement of Understanding with the Hospital Care Association gives that Board of Trustees control of setting up their costs, deciding how much it cost to run Blue Shield. how much it costs to run Blue Cross. They can take all of the cost items they want to under Blue Shield and switch them over to Blue Cross, and we don't have anything to do with it.

If they put four men on there plus men who are executives plus people who drive three Cadillacs and object to a doctor driving one and we give them the power of setting up this budget with four hospital administrators sitting in there, we will get cut right across there. Any time they get into financial trouble Blue Shield will suffer.

All Hospital Care has to do as far as I am concerned is say they want this, except two things, namely, (1) that they elect their Board as they are now elected; and (2) it is not necessary for the Medical Society to underwrite Blue Shield. If they will put those two clauses in there and these fees are set as we now set them and we will pay them regardless of how much money is collected, but as long as we are going to pro rate, as long as we are underwriting their program, I think we are foolish to put our treasury in the hands of someone we don't select.

DR. BONNER: I would like to call attention of the Council to the fact that the Insurance Committee that has worked on this thing for years and has argued against this same thing that Dr. Baker is talking about, and it recommended last year that we not do it. Still we went ahead and approved it. But under the agreements we had with them at the time they were told they were to

make their Board just like ours. Now that they have changed it, I think we would be willing to accept it and not go along with Dr. Baker. If we cannot have a little voice in it, I think we ought to get out of it and stay out of it.

DR. PASCHAL: I don't think the Council ought to impose its wishes on the whole membership. I think we ought to give the doctors what they want, and it is my feeling that a great many of them want to have Blue Shield made available for the Hospital Care Association. If that is not what they want, it suits me perfectly all right to go along as it is. but I thought you ought to have the opportunity of knowing this phase of it.

DR. SAMS: Mr. Chairman, this is the age-old thing we have fought out every year. We have fought it out for ten to twelve years. Last year we made the proposition to the Hospital Care Association that they come to us and come in with the Blue Cross and Blue Shield on exactly the same basis as the Hospital Saving Association, and it was okayed. We gave them that right, even elected doctor members of this Society to go to it to serve. Those men have been embarrassed by the thing that they met over there. I know they have.

Until Hospital Care Association meets exactly the same demands as to understanding as Hospital Saving Association I will never vote for this thing.

DR. KOONCE: I move that we reaffirm our stand.

(The motion was seconded by Dr. Sams.) PRESIDENT BAKER: I think there is some other information you should have. When all this was going on in Durham and I made an effort to the best of my ability to get these people to change their way of thinking. I called up Mr. Herndon and told them when I found they were meeting at eleven o'clock in the morning that I was scheduled to operate but I would cancel any operation I was doing and hold myself in readiness to come to their Board of Directors meeting and explain medicine's viewpoint.

He said, "That is fine."

I said, "If you would prefer that I sit outside the door, I will be available when you want me, and I will sit there all morning."

I have yet to have the courtesy of a call to say whether or not I was wanted.

CHAIRMAN JOHNSON: There is a motion on the floor, and it is seconded. The motion is to the effect that we reaffirm our stand which we took last year. If I am correct, the stand last year was that they were offered Doctors Program of Blue Shield

if they conformed exactly to the circumstances under which Hospital Saving oper-

ated.

However, in a separate motion which was passed by the House of Delegates—if I am wrong, correct me-we did confirm that there would be appointed from this Medical Society four members to their Board of Trustees. That is the motion; that is the intent of the motion, I believe, that Mr. Koonce made. Is there further discussion on this

DR. BONNER: Did those four men re-

appointed serve this year?

CHAIRMAN JOHNSON: Yes.

DR. RONNER: How could they serve if

they did not meet our agreement?

CHAIRMAN JOHNSON: That was a separate motion. One was regarding Blue Shield; the other was regarding representation which I think, personally, was good. If we cannot convert them, let's put somebody there who can help us convert them.

PRESIDENT BAKER: The conversion

went the other way.

CHAIRMAN JOHNSON: The motion is on the floor, and legally it is I believe as I have explained it. Is there further discussion aimed to this motion? All in favor of the motion of Dr. Koonce as has been explained, let it be known by saying "aye"; all opposed?

DR. PASCHAL: I will vote no.

(The motion was carried.)

CHAIRMAN JOHNSON: Is there further discussion of the Medical Society on the Board of Trustees?

PRESIDENT BAKER: I move that we continue to nominate and elect members of the Hospital Care Board of Trustees as we are now doing.

CHAIRMAN JOHNSON: It wouldn't really require a motion. We are now doing

that.

(The President resumed the chair.)

PRESIDENT BAKER: I have a message here which reads:

Regret having to miss my first state meeting in 25 years. Love to all. Use my banquet ticket as you wish. Tell Donald I cannot be with him this year. Feel free to make another choice. Rachel Davis

Dear Jim:

I doubt the wisdom of undertaking the trip to Asheville with a broken ankle. Of course, I am very anxious to go and if I am not mistaken, this will be the first meeting I have missed since the year 1925.

If you don't see me there Monday morn-

ing you will know that I am not going. Remember me to the boys.

Cordially yours,

/s/ J. Street Brewer, M.D.

PRESIDENT BAKER: Will you please acknowledge those in the name of the Board?

MR. BARNES: I shall do that.

I want to report if I may that some time in mid-March Dr. Millard Hill, who is Chairman of the Committee on the General Practitioner of the Year for Wake County, came to my office, and in conversation indicated that Dr. Glenn Judd would be a candidate for this award from Wake County. There has never been any official certification by the Wake County Medical Society of his candidacy despite the fact that we have written to the Secretary and the President to the effect that we have had none. There has, however, been submitted a two-page brochure. I am going to turn that over to the Committee on Rural Health which is charged with the decision of nominating three candidates for consideration the House of Delegates, but I guess we will have to regard this not official.

DR. PASCHAL: How many candidates

are there?

MR. BARNES: Three in addition to this

one, if this one was official.

PRESIDENT BAKER: Has this officially been passed within your own meeting?

DR. PASCHAL: I don't believe it has been officially acted on at a county society meeting. The committee has considered it. They have talked to the President about it.

PRESIDENT BAKER: Who is the Presi-

dent?

DR. PASCHAL: Vonnie Hicks is President of Wake County.

PRESIDENT BAKER: Was your com-

mittee empowered to act?

DR. PASCHAL: I don't know that they had specific authority to act, but they selected this man, and their meeting came before they had reached a decision about Dr. Judd.

PRESIDENT BAKER: Do I have a motion that we contact Dr. Hicks, President of Wake County, and see if this is an official thing from his County Society?

They have not had a

DR. PASCHAL:

meeting. PRESIDENT BAKER: He could speak if he wanted to take the responsibility.

DR. BEDDINGFIELD: I so move.

(The motion was seconded by Dr. Paschal, was put to a vote and carried.)

PRESIDENT BAKER: George, will you get that information if you can?

DR. SAMS: Mr. President, while we are

talking about the General Practitioner of the Year, I would like to suggest to this Council that we have the North Carolina Academy of General Practice that has about 430 members in North Carolina. We are young, but we are growing. We are the General Practitioners, and I would like to suggest that we think in terms of working out a plan for another year that the North Carolina Academy of General Practice be vested with the selection of the General Practitioner of the Year and bring their recommendations to the body of the State Medical Society. That is just a suggestion, Mr. President, and something for us to think about. I think we are entitled to bring three men to the Council and to the State Society. This is just a suggestion, that is all.

DR. BRINN: If there is any justification for selection of a General Practitioner of the Year, I think probably the North Carolina Academy of General Practice should make the selection, but to my way of thinking it is just transferring to the North Carolina Academy of General Practice a function which the North Carolina Medical Society passes on and that is determined a great deal by the width of the brochure and the

man that nominates him.

I personally don't see where we are accomplishing a great deal. Maybe it is good public relations, I don't know; but I question whether some of the men that we have selected as Practitioner of the Year are really the Practitioner of the Year.

I guess we will have to continue it because the AMA wants it done, but it is just passing from one group to another group the same sort of situation. If it is going to be passed on, they are the ones that should do it, I agree with you. I think it is just a farce.

DR. BEDDINGFIELD: We are all aware of the fact that there is no one practitioner who can be picked out above all others. However, this is a very valuable thing in public relations. We get clippings from all over the state.

PRESIDENT BAKER: We have had no motion. Is there any other discussion of the matter?

DR. BRINN: There is one thing I would like to bring up which is constantly brought to my attention through members of the First District, and that is when patients are referred to them by the Welfare Department for purposes of a survey by the Vocational Rehabilitation people they more often than not lose contact with that patient from the time he leaves their office until they see the patient walking down the street and realize he has probably had an operation and he

has a wooden leg or he has had one taken off.

Couldn't there be a little closer liaison between the Vocational Rehabilitation group and the original physician in charge of that patient? They just lose contact completely.

patient? They just lose contact completely.

PRESIDENT BAKER: They are people who are not paid too well. They try to do their job. They lose these people constantly because of lack of a decent salary to pay them.

I think the thing you complain of is mostly due to inadequate individuals not knowing

how to handle this thing sometimes.

DR. AMOS JOHNSON: That is one of the things that the Negotiation Committee has heard as much or more about in the last year from individual doctors as anything else, the fact that without consultation, without writing you or consulting you at all, one of these men, however inadequate he may be, that you have just described, tells the patient in just these words, that his doctor is not competent to take care of this, and if he is in the picture we will do nothing for you. He goes on to say, "I will send you to so-and-so who is 'one of my boys.'" That is the way it is expressed. He has his "boys" who are top men all over the state who do this, that, or the other and if you don't go to his boys you are out.

I do not like it. I think it is gross discrimination and the worst sort of failure to permit the selection of the doctor.

PRESIDENT BAKER: Would you make a motion to the effect that the members of this Board, the Vocational Rehabilitation Board, be responsible to the Medical Society and when these instances come up that that goes to those people representing medicine on that Board?

DR. BONNER: I would like to make a motion that this thing be turned over to our Negotiations Committee, and let them fight the battle.

PRESIDENT BAKER: There is a motion that this matter be turned over to the Negotiations Committee. I don't believe the motion is necessary.

(The motion was seconded by Dr. Sams.)

PRESIDENT BAKER: Could it be a motion to the effect that instead of being turned over we ask the Negotiations Committee to look into it?

(The suggestion was accepted, the motion was seconded and put to a vote and carried.)

PRESIDENT BAKER: I have one other thing to bring up from my point of view. Each of you gentlemen was handed a slip

that had on the back of it, "Know your-

self."

Your President may be getting you into some trouble, we may be criticized for this, but Jim Barnes and I went to Washington in January and we were told in no unemphatic terms by our friends that if doctors didn't wake up to the fact that they are going to have to get some kind of organization that they can come in and help our congressmen.

I hope when we get home we will get the individual information on every doctor in the State of North Carolina on that questionnaire. I think our future presidents, when we are in a spot, as Jim and I were early in the year, will be in a better position than we were. When we were picking your committee to serve under Dr. J. P. Rousseau we didn't know who should be on that committee. We had to go to Washington to have congressmen tell us which doctors they knew and which doctors they would listen to.

I hope you people, for me and the future presidents, will work on this "Know your-

self" thing and push it.

MR. ANDERSON: I would like to thank Dr. Baker and other officers and Jim Barnes and Dr. Poteat for the best cooperation you could ever expect

and the best leadership on legislative matters during this session of the General Assembly. We have had a lot of them, and Dr. Baker has scrutinized everything and made some mighty fine suggestions, kept me on the ball as far as I could be kept there. Jim Barnes has scrutinized hundreds of bills at this session.

PRESIDENT BAKER: Thanks.

MR. BARNES: Dr. James Raper, who was on the Committee of Arrangements here in Asheville, informed me yesterday that the Buick people here will furnish an automobile to any of the officers who do not have an automobile through Deal-Buick Company.

PRESIDENT BAKER: May I take this opportunity to thank you people, particularly some of the Commissioners, in fact all of the Commissioners, for what you have done. I am sorry I didn't carry my part of the load from the latter part of February on. I didn't do much except what I could do by telephone.

I have not had a coronary so don't feel sorry for me, don't help me up and down steps.

If there is nothing further, we will adjourn. Thank you again.

(The meeting adjourned at twelve-ten o'clock.)

MEETINGS OF THE HOUSE OF DELEGATES

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA 105th ANNUAL MEETING OF THE HOUSE OF DELEGATES City Auditorium Asheville, North Carolina MONDAY MORNING SESSION May 4, 1959

The first session of the House of Delegates held in connection with the 105th Annual Meeting of the Medical Society of the State of North Carolina convened at ten o'clock in Asheville, North Carolina, in the Auditorium, Dr. Lenox Baker, President of the So-

ciety, calling the meeting to order.

PRESIDENT BAKER: This session of the House of Delegates of the Medical Society of the State of North Carolina is now in session. I would like to call on the Reverend C. Grier Davis, the Pastor of the First Presbyterian Church of Asheville, North Carolina, to render the invocation opening this session.

THE REVEREND C. GRIER DAVIS:

rendered the invocation.

PRESIDENT BAKER: Dr. John Rhodes, Secretary of the Medical Society, has a few announcements.

DR. JOHN RHODES: Dr. Baker, Gentlemen and Ladies, on behalf of the Committee on Arrangements, it is my privilege to welcome you to Asheville, and I might say that that Committee is comprised of Dr. Ted Raiford, Joshua F. B. Camblos, M. D. Hill and myself, and we operate under Dr. Beverly Raney's Commission. I would remind you that the exhibits, some ninety-eight technical exhibits, and twenty-eight scientific exhibits, are located immediately beneath, and we hope that all of you will take the time to visit those exhibits. And we also have for you a Civil Defense exhibit on Haywood Street. There is an emergency hospital unit set up there for your interest.

PRESIDENT BAKER: It is with regret that I have to tell you that our Speaker of the House, our beloved Westbrook Murphy, is not being allowed to participate in these functions today. I am also going to tell you with a great deal of joy Westbrook does not have a coronary. Westbrook is doing all right, and he can get back into harness pretty soon, but not today. We will miss him. We will miss his colorfulness.

We are fortunate in having Donald Koonce as our Vice Speaker, who moves in and takes over today. In passing I would like to say that no one knows how much I have leaned on Dr. Koonce during the past year, particularly during my year as President-elect and getting ready to serve in this office. We are fortunate that Donald has had the training in this Medical Society that he has, and that he is a man who has developed into a beautiful maturity and who is invaluable in the meetings of our Executive Council. Donald, I want to thank you now for what you have contributed to my life in the past few years, and I am turning this house over to you.

(Dr. Donald Koonce assumed the Chair.) SPEAKER KOONCE: Thank you. Lenox, for those kind, unwarranted words.

The first action that I would like to take as substitute Speaker of the House, is to ask for the report of the Committee on Credentials. Dr. Herring, do you have a report?

DR. HERRING: There are about 110 Delegates present. I don't have the exact

number yet.

DR. RHODES: Mr. Speaker, this House is comprised of 160 Delegates, 19 past Presidents and 2 past Secretaries, making a total of 181. I declare a quorum present, Mr. Speaker.

SPEAKER KOONCE: Thank you, Dr. Rhodes.

The first thing that I would like to do after that, after we are officially in session, is to tell you how much — and I know you feel the same way I do — I regret that Dr. Murphy can't be here today. As Dr. Baker said, he is doing well. I saw him Saturday night. He is bright and cheerful, and looks very well. And I understand he is coming to the General Session tomorrow morning to be presented with his President's Medal along with some of the rest of us.

I beg your indulgence and hope that you will be a little bit patient with me. You know. I cannot take Westbrook Murphy's place, and I don't intend to, nor do I want to. And there will be many mistakes that I will make, so please don't expect the wonders from me that you have always had from him.

I had several things that I wanted to say concerning him, but he has written a short note to the House of Delegates which I think would express things a little bit better.

MEMORANDUM TO THE HOUSE DELEGATES

With reluctance, with disappointment, with chagrin and with apologies, I must inform you that physical disability will prevent me from serving as your presiding officer at this year's annual meeting.

The great North Carolina physician. Dr. Paul McCain, once remarked that the apex of his career was the Presidency of the Medical Society of the State of North Carolina, because in that incidence he was selected and elected by his friends, those who knew him best. Without hesitation, I can agree with Dr. McCain's evaluation.

You have honored me more than most men and certainly far beyond anything I deserved. Ten years ago I took office as your President and now I conclude my sixth year as the Speaker of the House of Delegates. Against such a background I have presumed to request the Vice-Speaker of the House, Dr. Koonce, to arrange to have this unscheduled memorandum read at the opening session.

I wish that I had the capacity to say something so profound as to be worthy of repetition through the years and something which would serve as a constant inspiration in your struggle to preserve the private practice of medicine but I find I am entirely inadequate. I can only repeat some of those things I have said to you many times before and reaffirmed my conviction that individual freedom in medicine is worth any sacrifice.

The Medical Society of the State of North Carolina has gone a long way toward creating the mechanism to deal with both internal and external destructive influences. No other function of the Society has ever approached in importance that of the "Committee on Negotiation." How wonderfully the Committee has so far performed! With every iota of my mind and my soul, I urge that you never allow it to deteriorate and never permit it to become diverted from its original purpose. Above all, you must select as members only those who are forceful and intelligent and who are dedicated to the point of real self-sacrifice.

Passive resistance is a powerful force. One little man, Mahatma Gandhi, used it to destroy an empire and change the history of the world. Properly employed, passive resistance can do much to preserve the private practice of medicine in North Carolina. At this time the future looks black indeed and I am convinced that socialism and the complete welfare state are inevitable. It would be a wonderful thing if the Medical Society of the State of North Carolina could, along with that altogether worthy organization, "The Association of American Physicians and Sur-

geons," remain an island of liberty which refuses to be submerged in the sea of socialism and which stands firmly until the storm of paternalism shall have blown itself out.

This is my means of welcoming you to Asheville. May your visit here be pleasant and profitable. I ask for God's blessings upon you as individuals and as a group. May your meetings be characterized by your usual dignity and tolerance and may your decisions reflect the comprehension and intelligence which is characteristic of the House of Delegates of the Medical Society of the State of North Carolina.

I think that speaks for itself.

Next there is a Resolution that I would like Mr. Barnes to read and have your action on it.

MR. BARNES: Mr. Chairman, Resolution:

Whereas, Dr. G. Westbrook Murphy has gained great distinction for his long service to the Medical Society of the State of North Carolina in the capacity of delegate from his component county medical society, as President of the Medical Society of the State of North Carolina, and as the Speaker of the House of Delegates during the course of seven Annual Meetings; and

Whereas, Dr. G. Westbrook Murphy has been prevented from carrying on his great usefulness to the Medical Society as exemplified over these years due to a current illness which prevents his participation in the deliberations of the House of Delegates; therefore be it

RESOLVED, that the House of Delegates of the Medical Society of the State of North Carolina express to Dr. G. Westbrook Murphy its high esteem for his record of leadership and guidance tendered to this Society over the years and that this House of Delegates express the profound wish that Dr. Murphy experience a speedy and complete recovery to the point that he may yet enjoy the extension of many useful years of service to medicine and to this Society.

DR. CHARLES STROSNIDER (Wayne County): I move the adoption of the Resolution.

(The motion was seconded by Dr. Hubert Poteat, Jr., was put to a vote and carried.) SPEAKER KOONCE: I hope all of my duties will be as pleasant.

Does anyone here have a distinguished guest that he would like to introduce? We will call later for any that may come in.

Next is the announcement of a Committee to read and discuss the President's two messages. I appoint Dr. Jacob Shuford as Chairman, Dr. John Kernodle, and Dr. Willard Goley.

I have two communications that I think should be read. This is to Mr. Barnes:

Dear Jim:

I doubt the wisdom of undertaking the trip to Asheville with a broken ankle. Of course, I am very anxious to go and if I am not mistaken, this will be the first meeting I have missed since the year 1925.

If you don't see me there Monday morning you will know that I am not going. Remember me to the boys.

Cordially yours, s J. Street Brewer

A telegram to Mr. Barnes:

Regret having to miss my first State meeting in 25 years. Love to all. Use my banquet ticket as you wish. Rachel Davis.

In starting our meeting I would like to request that everybody have free and full discussion of every problem which comes up, but limit your discussion, please, as much as you possibly can and give me the right to call you a little bit if you take too much time.

I think that the way this House of Delegates has been arranged will save a considerable amount of unnecessary time. As you can see, we have already, according to the instructions of the House of Delegates last rear, omitted the roll call. That is a considerable saving. And I think we can have a comparatively brief meeting, in comparison with some in the past, if we will limit our discussions to the pertinent facts and points that we are trying to discuss.

Now, I would like to call on the President

to give his message.

PRESIDENT BAKER: I bring you no message. I think at this time we should have a report of the business of this House and that is all we need today. I hope I may bring

you a message tomorrow.

The first thing I would like to report to you is that our system of setting up Commissioners to try to carry on the business of this Society, as far as I am concerned, is most successful. I thanked Donald once this morning, and I will thank him again for the work he and his Committee did in working it out, and I thank Pete Schoenheit for carrying it through last year to where it got to me that all I had to do was appoint Commissioners. It has made the Presidency a relatively easy job. We tried to pick good Commissioners for you. I think one thing is brought out. In the past we have tried to develop officers, people who could carry

on the affairs of this organization, with efficiency. I am quite certain we can say now that in the future we will not be looking for one who can do this, but rather who are we going to take out of the group that can do it. These Commissioners are getting terrific experience. If you will look the list over there may be one or two exceptions, but most of them are young men. They, as far as I am concerned, know the affairs of this Society, and in the future if we continue it and put proper young men in there we will solve many of our problems of having people that have "know how."

I would like to report that Jim Barnes and I spent a day in Washington in January. It was an interesting trip. We learned much. I think we made good contacts. I think we let our Congressmen know what the position of Medicine is in this State in their affairs.

and our willingness to help.

Dr. Westbrook Murphy sent us a message this morning. In it he referred to the Negotiations Committee, a very delicate situation. Many times, our Negotiations Committee, in trying to protect Medicine, will be dealing with people who have already been taken over by "federalization." I don't use the word "socialization." They are our friends, and I think our Negotiations Committee will tell you that many people with whom we have to negotiate now are in the same boat we are in, and the main thing that we will have to do with them is to set a common goal and try to meet it together.

That island that Dr. Westbrook Murphy suggested we build and stand out there against socialization or federalization, if we are going to build it I don't think we are going to build it with rocks; I think we will have to build it with ballot boxes. And we must remember this, that no longer is our business run by ourselves. No longer is any business in the United States of America run by ourselves. It is run by a group of people in Washington, most of them fine gentlemen, most of them willing to serve, most of them trying to look over a thousand bills at one time. If we don't cooperate with them, if they do not know us, our island will not stand up.

We have still the problem of the 65 year, or older, individual in our nation that some people in politics have picked as a ballot-getting program. I think if we do not meet the situation that that program will be federalized. I hope we can keep that in mind today when we consider any recommendations that might come before this House. I plead with you to consider the seriousness of the necessity of our giving what we would

call the best answer we can give and that

we give it today.

The Veterans Administration problem still exists, the same as it always has. It may be getting a little worse. There are some indications of the waking up of some organizations other than our own to the seriousness of it.

Medical Care, I presume, in spite of the beautiful job by Dr. Dave Cogdell and his Committee, has gone by the wayside (in reference to cut-back regulations), as far as

I am concerned.

Another problem we leave with you that we have not solved this year. You will have a report concerning headquarters. I think we should consider it seriously and we should appoint a Committee or maintain the present Committee with perhaps a little bit more authority than they have now.

Now, those are the items that I think face you during this coming year. I will leave it to you, Dr. Reece, to go on and try to get

them solved. Thank you!

SPEAKER KOONCE: I refer to you information on something which I think is very important because in the past the election of three officers namely, to the Medical Care Commission, Hospital Saving Association, and Hospital Care Association, has been made in the General Assembly, as an open election. That was changed last year by the Constitution and By-Laws, so that now they are elected by the House of Delegates, and these elections will be brought up this afternoon under New Business for election of those three offices.

Another thing is, as you had by note, the organization of districts for selection of a Nominating Committee will be held this afternoon at approximately three o'clock, whereas in the past it has always been held at 9 o'clock at night. Now that, as I understand it, is simply a custom, or has been a custom, and is not part of the By-Laws and can be changed. So that will be held at three o'clock this afternoon. That is so that those of you who may have to go out for a short period of time will be here for those things.

The next thing is the report of the Secretary, Dr. John Rhodes. That report is in

the compilation.

REPORT OF THE CONSTITUTIONAL SECRETARY MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA May 4, 1959

By action of the House of Delegates at the 1958 Annual Meeting, the duties and responsibilities of the constitutional secretary were changed in accordance with the recommendation of the Edlund report. The function of Treasurer was transferred to the office of Executive Secretary whose title became Executive Director, While this arrangement has added measurably to the duties of the Executive Director, it has facilitated the mechanics of Society business and has relieved the constitutional secretary of much arduous detail. I am happy to report that the fiscal affairs of the society are in good order as will be shown by the report of the auditing firm of A. T. Allen & Company. In fact, for the first time in three years, the society has operated within its budget due to careful management by the executive director with the wise counsel of the finance committee.

Active membership of the society on December 1, 1958, was 3,176 representing approximately three-fourths of the registered physicians in North Carolina reported in the roster issued June 30, 1958, by the Board of Medical Examiners. On April 1, 1959, current dues had been paid by 2,596 mem-

bers

In an effort to simplify a top heavy committee structure, the 1958 House of Delegates authorized the President to group the Committees under six commissions, each with a chairman responsible to the President and Executive Council for the activities of his several committees. The Nominating Committee, being elective, was excluded from this reorganization.

The executive staff, despite cramped quarters and mounting complexity of the business of organized medicine, has performed its functions in a manner to reflect credit

upon the society.

Respectfully submitted, John S. Rhodes, M.D. Secretary

Executive Director, Mr. James T. Barnes, has a report in the compilation.

REPORT OF THE EXECUTIVE DIRECTOR Medical Society of the State of North Carolina May 4, 1959

Mr. President, Gentlemen of the Executive Council and Members of the House of Delegates: I desire to continue my report in relationship to that area of my general duties as Executive Director in the administration of the functional affairs of the Medical Society of the State of North Carolina.

It should be recalled that the House of Delegates in 1958, recognizing an unbalanced budget estimate for the year 1958 which had then been in operation four months, formulated a mandate there should not be deficit spending in the future. I wish to report to

you that we have administratively dealt with the problem of deficit spending through all of the months of 1958 by resorting to two courses: 1) diminishing expenditures wherever such was within our controls of administrative function and 2) increasing the revenue of the Society by pursuit of every proper means of influencing the production of earnings in the areas of dues collection, advertising sales and exhibit sales. Thus we have been insistent in the effort to accrue all dues rightfully due to be paid to the Society. The results, as may be noted from the audit report, scarcely met budgetary income estimates at the beginning of the year. We can report that the expenditure accounts in the budget were adhered to in a respectful manner and some of the economies we had instituted even before the year began were reflected in the economy of our operations. In respect to sales of advertising and exhibit space sales, we are able to report banner years. A review of the audit report will indicate our wide margin of success without more detail here. However, the race between the production costs of the Journal and the ever increasing advertising income must be reckoned with one day as a problem for this Society, Finally our administration showed a margin of operational profit for 1958. In discussing our stewardship for 1958, you should look at the fact that two major functions devolved as additional undertakings on our administration in 1958—that of Treasurer in May and that of managing secretary for the Committee on Negotiations in September, thus relieving some expense as a factor in both instances, but the taking on of more and ordorous duties. Such extension was quite serious and has surely made the administrative operation more difficult during the year. It is our hope that both undertakings have been carried out efficiently and with satisfaction to the Society and its officials. Gratitude is paid to the staff at Headquarters Office for its strength and contribution. It now has to recognize that individual responsibility has increased measurably upon each one involved and all must be prepared to carry a greater share of the work load as we move on in the year 1959 and the future.

I said a year ago I was accustomed to pull in harness with Dr. Lenox D. Baker, your President. As you know he is a doer and this year of Society activity has born many undertakings which carry his imprint of good concept and efficiency. No man has more concern for the Society and its welfare, nor no man has made greater effort in its behalf than Dr. Baker has over the years.

and particularly this year of his presidency. His extended effort, I am sure, contributed to his recent illness and our generated prayer is that he find the determination to conserve his energies in areas that we may have the wisdom of his counsel in the months and years to come. He has been a wonderful fellow traveler in our work for the Society.

I said a year ago that I would undertake the new assignments with an element of humility. I find nothing in my constitution to change that determination as I seek to have my work laid down for the next year by the new President, Dr. John C. Reece, I am sure that his capacity for strong leadership and direction will stand me in good stead as I go about facing the Society's problems and, under his direction, developing areas of function to solve such problems as he defines for us. In doing so we shall continue to work humbly for the good of all men in medicine. It is our special expressed hope that the members will at all times bring problems to us that these may be channelled to the resourceful officers of the Society who can study and direct our course upon them. With good will most can and will be solved in that manner.

The following constitutes a report, in measuring some of the efforts and accomplishments of the entire staff at Headquarters:

- A. Incoming items of processable mail 19,432

 B. Letters, personal and general, dispatched 31,710

 C. Public Relations Bulletins, dispatched *22,231

 D. Total mail items prepared and dispatched 19,432
- patched 53,941

 E. Telephone communications, local, prepaid and toll 4,796

 F. Telegrapms, received and dis-
- patched 78
 G. Reports, formal, miscellaneous, agenda, transmittals and mem-
- oranda 1,273
 H. Review of literature and reports (interpretative) 986
 I. Personal conferences 1,069
 J. Meetings attended 199
 K. Releases to press 664

403

L. Releases to radio

* Additional to item B

There has been a gain in membership during 1958 of 33 members. The Total number at December 31, 1958, was 3,171**. This mark, again, was the highest in the history of the Society and somewhat indicative of a

^{**} Not including 53 deceased members who had standing 1958-59.

growing vital organization. We believe there has been no trend toward loss of members by reason of the due increment effective for 1959 nor, yet, in regard to the requirement of dues of Life Members where active and prior to the attainment of age 70. So, we judge that the membership prospects for 1960 is for an increase in the size of the organization steadily toward the 4,000 mark which some have estimated we should reach. As of April 28, 1959, there were 3,043 members in good standing for the year against 3,005 on the same date a year ago—a gain of 38 members. We shall expect to experience a total membership for 1960 in excess of 3,300 members.

You will have in hand the Compilation of Committee reports of activity for the year 1959. In addition there are to be reports from the six areas of COMMISSION activity and recommendations upon which the Executive Council and House of Delegates will be expected to act. We hope that these have been developed efficiently in so far as the administrative staff is involved. We should report that the committee work has been observed in liaison through all the months of the year, particularly involving week-end duty, and that the committee effort in the year 1958-59 has been at an all time high.

A reference is here made to the Audit Report for information in regard to the 1958 operation of the business of the Journal particular reference being made to that section indicating the income from the sale of advertisement local-national and the sales of subscriptions and rosters, and to the "B" budget account reported upon with reference to authorized expenditures and to actual expenditures. Despite a marked growth in advertising patronage the cost of producing the Journal not only exceeds the budget estimate of expense but exceeds the increased revenue income developed through our managing effort with the Journal.

In concluding the administrative enumeration of activities, we report that the physician placement service still operates to serve the profession and the citizens of the State in areas of need for medical service. We are glad to commend on a recent review of our effort by the Sears, Roebuck & Company Foundation which has concerned itself with promoting good physician placement throughout the country. We were complimented at their evaluation of the effort which your Society organized twelve years ago and in which so many people still find usefulness in respect to developing and maintaining adequate medical services in all areas of North Carolina.

I close this report with an expression of prayerful thanks to God for the strength and wisdom to carry the administrative burdens of the Society on a successful basis for you. And with a hearty expression of thanks to the Membership for the opportunity to so serve.

Respectfully submitted,
James T. Barnes, Executive
Director
Medical Society of the State
of North Carolina

Raleigh, N. C. April 28, 1959

THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA REPORT OF THE TREASURER May 1, 1959

To President Lenox D. Baker, to the Executive Council and to the Members of the House of Delegates of the Medical Society, this constitutes the first annual report as the Executive Director of the Society in the course of which there is the obligation to report, also, as your Treasurer. Under the budgetary controls, the constant knowledge of the President, the supervision of the Finance Committee of the audit procedures and the approval procedures of the Executive Council there are the ultimate in safeguards placed about the funds of the Society; so, the treasury function has been no great departure from previous functioning as your employee Director. Therefore the report will vary scarcely from previous reports prepared in the executive office in regard to previous reports on the treasury functions.

As Treasurer of the Medical Society of the State of North Carolina, it is my duty, imposed by the By-Laws, to bring to you annually a report of the general and fiscal operations of the Society. This report will cover the finances of the fiscal period, January 1, 1958, to December 31, 1958. Otherwise the report will deal with those activities in service function and attainments carried out over the period May 1, 1958, to April 28, 1959.

It is attested that all rightful revenue accruing to the Medical Society of the State of North Carolina have been fully collected relative to those currently due. These have been properly accounted for on the books of the Society, placed in the depository long selected for the safety and security of the Society funds and have been reported to the officials of the Society as required of the Treasurer. All matters related to the fiscal affairs of the Society, under the direction of the Committee on Finance, have been reviewed by quarterly audits of the auditing

firm first authorized to do so twelve years ago, and the manner and the acceptability of accounting for the fiscal affairs of the Society has been carefully audited at the close of the year 1958 and a statement in report of that audit has been prepared for you by the firm of A. T. Allen & Company of Raleigh, North Carolina. It is my sense of obligation to state to you that all disbursements made during that period of fiscal operations referred to above, though I have served in the capacity of Treasurer only from May 27, 1958, appear to be in line with authorizations of the House of Delegates and or the Executive Council. It is my further sense of obligation to state that the fiscal affairs of the Society has borne proper scrutiny and that performance has been in line with these authorities and that no question of the equitable and proper handling of all funds for the period can be justified.

The Report of the Audit for 1958, prepared by A. T. Allen & Company, certified public accounts of Raleigh, North Carolina, is attached hereto and forms a part of this report. It is respectfully asked that this report be considered and formally acted upon in the proceedings of the House of Delegates. I recommend that it be adopted.

Respectfully submitted, James T. Barnes, Treasurer Medical Society of the State of North Carolina

of North Carolina

Raleigh, N. C. April 28, 1959

MR. BARNES: I simply want to tender the official audit report made by A. T. Allen and Company which is required to be published in the transactions. You had a printed transcript of this through the mail prior to coming, so I will tender this. Now, our actual income for the year, as will be reflected by the audit report, was \$177,985.93, against expenditures, as authorized in the budget of \$168,536, so that the Society did operate in the year 1958 with a profit of \$6,914.84 net, which will be reflected in the audit report. I simply wanted to bring those figures to your attention.

Auditor's Report

Medical Society Of The State Of North Carolina, Incorporated Raleigh, North Carolina

12 Months Ended December 31, 1958

OFFICERS

Dr. Lennox D. Baker, President	Durham, N. C.
Dr. John C. Reece, President-Elect	Morganton, N. C.
Dr. Amos N. Johnson, First Vice-President	Garland. N. C.
Dr. Kenneth B. Geddie, Second Vice-President	High Point, N. C.
Dr. John S. Rhodes, Secretary	Raleigh, N. C.
Mr. James T. Barnes, Executive Director	Raleigh, N. C.
Dr. G. Westbrook Murphy, Speaker-House of Delegates	Asheville, N. C.
Dr. Donald B. Koonce, Vice Speaker-House of Delegates	Wilmington, N. C.

Chairman and Members of the Finance Committee

Medical Society of the State of North Carolina, Inc.

Raleigh, North Carolina

Gentlemen:

Pursuant to engagement, we have audited the books and records of the Medical Society of the State of North Carolina, Inc., Raleigh, North Carolina, for the period beginning January 1, 1958, and ending December 31, 1958, and present herewith our report.

Exhibits and Schedules

In presenting to you our findings, as the result of the audit, we have prepared four Exhibits and four Schedules, as outlined in the Index, which are attached hereto as a part of this report.

Balance Sheet-Exhibit "A":

The first statement is a list of the Assets, Liabilities, Reserves and Net Worth, which we designate as Balance Sheet, December 31, 1958, Exhibit "A". This statement has been divided into two sections. One contains the Current Operating Fund, which represents the Current Assets, Liabilities and Reserves. The other has been designated as a Capital or non-Operating Fund containing the office equipment, real estate, and capital stock owned and used by the Medical Society at estimated values established in a prior year, plus actual cost for purchases during the last ten years.

The Cash on Hand and in Bank is made up of \$50.00 Petty Cash Fund, \$5,195.05 cash in the First-Citizens Bank and Trust Company, Raleigh, North Carolina, and \$994.78 of cash on hand. The cash on hand was deposited January 2, 1959, and was verified by

means of reconciling cash through the date of our audit. The Cash in Bank was verified through a reconciliation of the balances as shown by the records of the Medical Society with a certificate which was obtained independently from the bank. This reconciliation is shown in detail in Schedule—1 of the report.

Accounts Receivable — Regular in the amount of \$2,174.28 are shown on the Balance Sheet and, in the main, represents the total of several uncollected balances due for local advertising in the State Medical Journal. Verifications were forwarded on these accounts and all differences reported were

satisfactorily cleared up.

Accounts Receivable—National Advertising in the amount of \$7,475.78 represent November and December, 1958, National Advertising in the State Medical Journal of \$3,952.48 and \$3,523.30, respectively. These amounts were confirmed directly with the State Medical Journal Advertising Bureau. The November amount was received in January, 1959.

Prepaid Office Supplies in the amount of \$228.00 represent supplies received and on hand at December 31, 1958, but applicable to

the operations of the year 1959.

The investment in United States Defense and Savings Bonds is shown at cost value of \$44,368.00, in the Balance Sheet, and in detail in Schedule—2 of this report. The Series "F" and "J" Bonds have an increment in value, due to lapse of time since date of purchase; however, this additional value has not been taken into account in this report. These bonds were counted on January 2, 1959 in the presence of your Executive Director, Mr. James T. Barnes.

The real estate, capital stock, and office equipment and furniture shown on the Balance Sheet in the amount of \$49,614.83 is listed in detail in Schedule—3. This represents an estimate made in a prior year and adjusted for purchases made during the last ten years. The items shown herein represent cost value of the equipment of the Medical Society. As there were no liabilities outstanding against this equipment, we have shown the entire amount as Net Worth — Capital Fund—in the Balance Sheet.

Under the "Liabilities" section we have listed those accounts, expenses, etc., incurred prior to December 31, 1958, for which statements or accounts were rendered or for

which payment was due.

The Accounts Payable—Trade, in the amount of \$8,375.29 represents unpaid accounts at December 31, 1958. These were confirmed 100% with the creditors by the

use of positive verifications. These unpaid accounts are for Journal and Roster publication, \$3,932.81, legal fees, \$3,600.00, and other expense, \$842.48.

The \$390.00, "Refunds of Dues Payable", represents State dues collected which are The \$250.00, refundable to the members. "Due American Medical Association", is 1959 A. M. A. dues collected in 1958. The \$287.50, "American Medical Association Dues in Escrow", represents dues paid to the State Society but which cannot be remitted to the National Society at the time due to diverse disqualifying reasons. The pay roll taxes, \$141.29 for the Society's Social Security and \$578.59 for employees' Social Security and Withholding, were paid during the course of the audit. The N. C. Sales Tax payable represents the liability for December, 1958 tax on journal subscriptions and roster sales as required by the sales tax law. The accrued salary of \$100.00 is the amount owed the new bookkeeper for the portion of December for which he worked. This amount was paid during the course of the audit. The \$28.90, "Due Hospital Savings Association", represents amount withheld from employees' salaries for hospital insurance during December, 1958 but unremitted at December 31, 1958.

The deferred credits of \$5,111.30 are for payments of \$3,455.00 made on technical exhibits space at the 1959 Convention, \$913.00 made on 1959 Convention Banquet, \$725.00 made on 1959 membership dues, and \$18.30 made on 1958 rosters. These remittances were received in 1958 and will be transferred to the income accounts in 1959.

The Reserve for Mental Hygiene of \$4,-215.03 is a reserve in the process of being built to \$5,000.00 to cover expenses and costs of the said committee on its rehabilitation work. To the balance in this account at January 1, 1958, of \$3,870.48 was added the unexpended Budget Appropriation of \$344.55 in 1958, resulting in the balance at December 31, 1958, of \$4,215.03.

The Reserve for Raymond Randolph Scholarship Fund of \$600.00 represents a reserve for the 1955 Essay Contest Winner, Raymond Randolph, Henderson, North Carolina. This amount is held in escrow for payment to a college which he chooses upon graduation from high school.

The Reserve for Medical Building Site represents the unexpended portion of the \$30,723.00 receipts received from the sale of Series "F" Bonds. The expended portion of this fund was \$26,104.55 and is set out in Schedule—4 of the report. This leaves a balance of \$4,618.45 not disbursed to date.

The "Net Worth" section of the Balance Sheet is comprised of two figures; \$35,789.22 being the balance of the Current Operating Fund for the year; and \$49.614.83 representing the balance of Capital Fund.

Statement of Net Worth-Exhibit "B":

The second statement is an analysis of the changes in Net Worth during the year.

The Current Operating Fund Balance was arrived at by adding to the balance January 1, 1958, of \$26,334.20, the amount of Net Income from operations for the current year—\$6,914.84, Expenditures in 1957 for Medical Building Site of \$350.00, and Expenditures in 1958 for Capital Fund of \$2,534.73, leaving a balance of \$36,133.77. Then, deducting therefrom the allocation to Reserve for Mental Hygiene Committee, \$344.55, gives the balance at December 31, 1958, of \$35,789.22.

The Capital Fund Net Worth Balance is derived from adding purchases during the year from operating funds for Capital Assets in the amount of \$2,534.73 to the balance January 1, 1958, of \$47,608.92 and deducting therefrom the charge-offs for obsolete equipment, \$528.82.

Statement of Income and Expenses— Exhibit "C":

A statement showing a budget comparison of the income and expenses for the twelvemonths period is shown in Exhibit "C statement is, in effect, a statement of operations for the year, and by examination it will be seen that the income of \$177,985.93 exceeded the expenses of \$168,536.36 by \$9,-449.57. However, there was included in the expenses \$2,534.73 in Capital Expenditures for Equipment. Eliminating these we show income from operations of \$6,914.84, which has been added to the unexpended balance of the Current Fund and shown in the Net Worth section of the Balance Sheet. Journal Budget was the only budget which exceeded the established and approved provisions, the excess being \$5,398.48 which is composed of the excessive cost of publishing the Journal.

In comparison with the Budget, actual income was more than the Budget anticipated by \$25,835.93. The main items accounting for this are \$19,015.35 more from National Journal Advertisement than was expected and \$5,710.00 more from the Sale of Exhibit Space. Further examination reveals that the total actual expenses were \$14,496.64 less than the budget provision. The main items accounting for this decrease are \$5,882.92 reduction in Executive Budget expenditures over the amount budgeted and \$7,305.88 reduction in the Public Relations Budget.

Cash Receipts and Dishursements— Exhibit "D":

A statement showing in detail the cash receipts and disbursements of the Society during the year under review is shown in Exhibit "D" which we summarize as follows:

 Cash Balance January 1, 1958
 \$ 1,864.15

 Cash Receipts During the Year
 263,291.55

 Total Cash Available
 \$265,155.70

Less: Disbursements During the Year: For Operations \$189,181.14 To A.M.A.—Dues 67,020,00

For Capital Expenditures 2,534.73

For Shirley Wilds Scholarship 230.00 258,965.87 Cash Balance December 31, 1958 \$ 6,189.83

We made a careful analysis of the cash transactions and, where practicable, traced the receipts to their original source. Disbursements for expenses were supported by cancelled checks and invoices issued in the regular course of business. We believe the funds have all been accounted for.

General Comments

A surety bond covering faithful performance of Mr. James T. Barnes, Executive Secretary, in the amount of \$50,000.00, is in force, held by the Medical Society and was examined by us. Also in force and examined by us were a Primary Commercial Blanket Honesty Bond in the amount of \$25,000.00; a fire insurance policy, with 80% co-insurance clause, covering fire loss on office equipment, books and records in the office of the Executive Secretary, Raleigh, North Carolina, in the amount of \$2,500.00; an Automobile Schedule Liability Policy; a Standard Workmen's Compensation and Employer's Liability Policy; and a Comprehensive General Liability Policy; and

As noted under Miscellaneous Budget — Employees' Retirement System (G-11), the first payment on the Pension Plan of the Society was made during the current year to Penn Mutual Life Insurance Company. At December 31, 1958, there were three employees eligible and covered under this plan. The plan became effective October 15, 1957 for employees who are full time permanent employees between the ages of twenty-five and fifty-five and have three years of continuous service if employed before October 15, 1957, or four years of continuous service if employed after October 15, 1957.

We were extended every courtesy and cooperation during the course of the audit; and we experienced no trouble in making our audit and obtaining the necessary information

for this report.

Scope of Examination and Opinion

We have examined the balance sheet of the Medical Society of the State of North Carolina, Incorporated, as of December 31, 1958 and the related statements of income and expense and net worth for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of income and expense and net worth present fairly the financial position of the Medical Society of the State of North Carolina, Incorporated, at December 31, 1958, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles for non-profit organizations applied on a basis consistent with that of the preceding year.

Very truly yours,
A. T. ALLEN & COMPANY,
CERTIFIED PUBLIC ACCOUNTANTS
By A. T. Allen,
Certified Public Accountant

(SEAL) Raleigh, N. C. February 5, 1959

> Medical Society of the State of North Carolina, Inc. Raeligh, North Carolina

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Statement of Income	
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Cash Receipts	
and Disbursements	Exhibit "D"
Schedules	
Cash on Hand and In Bank	Schedule—1
Invetment in United	
States Bonds	Schedule—2
Schedule of Capital Assets	Schedule—3
Schedule of Building Site Coa	
EXHIBIT "A"-BALANCE	SHEET
December 31, 1968	
ASSETS	
CURRENT OPERATING FUND: Cash On Hand And In Bank—(Schedul	e—1) \$ 6,239.83
Accounts Receivable—Regular	2,174.28 sing 7,475.78
Prepaid Utilice Supplies	
Investment in United States Savings Defense Bonds—At Cost—(Schedule—	and -21 44 368 00
TOTAL CURRENT OPERATING FUL	ND\$ 60,486.89
CAPITAL OR NON-OPERATING FUND—(SCHEDULE—3):	
Real Estate	\$ 26,104.55 28,310.28
Office Furniture and Fixtures	28,010.20
Journal Advertising Bureau	200.00 ING FUND., 49.614.83
TOTAL ASSETS	\$110,100.72

LIABILITIES, RESERVES AND NET WORTH LIABILITIES:	
Accounts Payable—Trade\$ 8,376,29 Refunds of Dues Payable	
Due American Medical Association 250 00	
American Medical Association 287.50 Due in Escrow 287.50 Due Hospital Savings Association 28,90 N. C. Sales Tax Payable .32 Pay Roll Taxes Withheld 578.59 Accrued Pay Roll Taxes 141.29 Accrued Salaries 100.00 TOTAL LIABILITIES \$ 10,151.80 DEFERRED CREDUTS: \$ 10,151.80	
Due Hospital Savings Association 28,90 N. C. Sales Tax Payable 32	
Pay Roll Taxes Withheld 578,59	
Accrued Pay Roll Taxes 141.29	
TOTAL LIABILITIES \$ 10,151.89	ì
DEFERRED CREDITS: Advance Payments on Technical Exhibit Space at 1959 Convention Advance Payments on 1959 Convention Base 1959 Conventi	
Space at 1959 Convention\$ 3,455.00	
Convention Banquet 913.00	
Convention Banquet 913.00	
Advance Payments on 1958 Rosters 18.30	
TOTAL DEFERRED CREDITS 5,111.30 RESERVES:	U
Reserve for Mental Hygiene Committee\$ 4,215.03 Reserve for Raymond Randolph	
Reserve for Raymond Randolph Scholarship Fund 500.00	
Scholarship Fund 500,00 Reserve for Medical Building Site 4,618.45	0
TOTAL RESERVES	5
Current Operating Fund	
(Exhibit "B") \$ 35,789.22 Capital Fund—(Exhibit "B") 49,614.83 TOTAL NET WORTH 85,404.0	
TOTAL NET WORTH 85,404.0 TOTAL LIABILITIES, RESERVES AND NET WORTH \$110,100.7	5
NET WORTH \$110,100.7	2
EXHIBIT "B"-STATEMENT OF NET WORTH	
12 Months Ended December 31, 1958	
CURRENT OPERATING FUND: Balance January 1, 1958\$ 26,334.20	
ADD:	
Net Income From Operations—	
Operations— Exhibit "C"	
Exhibit "C"\$ 5,914.84 Expenditures Made For Capital Fund	
Expenditures Made For Medical	
Expenditures Made For Medical Building Site—1957 350.00 9,799.57 Total	
Allocation to Reserve for Mental Hygiene	
TOTAL CURRENT OPERATING FUND—TO EXHIBIT "A"\$ 35,789.2	
1 CHE TO EMPLE IT INC.	2
CAPITAL FUND:	2
CAPITAL FUND: Balance January I, 1958	2
ADD.	:2
Balance January 1, 1998 31,006.32 ADD: Purchase Made During Year Through 2,534.73 Total	:2
Balance January 1, 1998 31,006,32 ADD: Purchase Made During Year Through Current Fund 2,534.73 Total \$50,143.66	:2
Balance January 1, 1998 31,006,32 ADD: Purchase Made During Year Through Current Fund 2,534.73 Total \$50,143.66	
Balance January 1, 1998 31,006.32 ADD: Purchase Made During Year Through 2,534.73 Total	33
ADD: Purchase Made During Year Through Current Fund 2,534.73 Total \$50,143.66 DEOUCT: Charge-Offs For Obsolete Equipment 528.82 TOTAL CAPITAL FUND—TO EXHIBIT "A" 49,614.8	33
Statement 1, 1968 31,096,32	33
Statement 1, 1968 1, 1968 31, 1968.92	33
Statement of Income Statement Statem	33
Saishee January 1, 1988 31,098.92	33
Statement of Income Statement Statem	33 35
Purchase Made During Year Through	33)5
Purchase Made During Year Through	33 35 6 6 6 6 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9
Name	33 35 05 00 00 00 00 00 00 00 00 00 00 00 00
Purchase Made During Year Through	33 35 5 0 0 3
Purchase Made During Year Through	33 35 30 30 4
Purchase Made During Year Through	33 33 33 33 33 33 33 33 33 33 33 33 34 35
Purchase Made During Year Through	33 33 33 33 33 33 33 33 33 33 33 33 34 35
Purchase Made During Year Through	33 35 30 30 4 31 31
Purchase Made During Year Through	33 35 35 35 35 35 35 35 35 35 35 35 35 3
Purchase Made During Year Through	33 35 30 4 51 2)
Purchase Made During Year Through	33 35 30 4 51 12)
Purchase Made During Year Through Current Fund	33 35 30 4 51 12)
Purchase Made During Year Through	cee))) 3 4 5 1
Purchase Made During Year Through Current Fund 2,534.73 Total	cee))) 3 4 5 1
Purchase Made During Year Through	000 000 000 000 000 000 000 000 000 00
Purchase Made During Year Through	cee)))))) 3 3 3 5 5 1 5 5 1 5 5 5 5 5 6 6 6 6 6 6 6 6 6

A	Salary - Frantiya											
	Salary—Executive- Director	10,360,00	10,350.00			D- 3	Woman's Auxiliary	800.00		861.32	,	61.32)
A- 5	Travel—Executive- Director	3,100.00	3,099.96		-04	D- 4	Expense of A. M. A Regional				,	02.02)
A- 6	Clerical Assistants Office .	15,000.00	13,947.15			m	Conference	200.00				200.00
A- 7	Equipment—				1,052.85	1 ota	l Extra-Func- tional Activity					
A- 8	Office Expenses—	1,600,00	1,596.74	(96 74)	D. IV. 7	Budget	3,735.00	\$	8,186.69	\$	548.91
Δ_ 9	Office	6,000.00 1,318.00	5,710.44 930.00		289.56	E- 1	Relations Budget: Salary—Assistant					
A-10	Audit	500.00	753.25		383.00 258.25)		for Public Relations §	8,280,00	8	8,280.00		
A-11 A-12		432.00 166.00	435.68 121.77	(3.63) 43.23	E- 2	Travel-Assistant	0,200.00	٥	0,280.00		
A-13	Membership Record System	554.00					For Public Relations	2,100,00		1,058.65		1,041.35
A-14	Publication, Report	504.00			554.00	E- 3	Travel— Committee					.,
	and Executive	100.00	75.30		24,70	F2 4	Chairman	300.00		231.60		68.40
A-15	Insurable Interest Insurance	1,371,00	1,370,80		.20		Clerical Assis- tants—Office	3,500.00		2,861.60		638.40
Tota	Executive Budget .8	47,225.00	\$ 41,342.08	\$	5,882.92	E- £	Equipment— Office \$	1,500 00	\$	939.42	\$	660.58
	Budget: Publication					E- 6 E- 7	Office Expenses	3,000.00		3,231.75	(231.75)
B- 2	of Journal .\$ Cuts for Journal	34,600.00 550.00	\$ 43,528.70 454.67	(\$	8,928.70) 95.33	E- 8		173.00		250,77	(77.77)
B- 3	Salary-Editor	2,310.00	2,310.00		00.00	E- 9	Executive Aids Audio Visual	150.00		88.03		61.97
B- 4	Salary—Assistant Editor	3,600.00	3,600.00			E-10	Depiction	400.00		149.45		250.55
B- 5	Office Expenses— Editorial	400.00	300.00		100.00		Distributions	400.00		363.28		36,72
B- 6	Office Expenses—	300.00	300.00		100.00	E-11	News and Press Releases	400.00		26.90		373.10
	Business Manager	300.00	136.18		163.82	E-12	Public Relations					
B- 7	Equipment—Busine Manager	200.00			200,00	E-13	Bulletins School	2,000.00		743.36		1,256.64
B- 8	Travel—						Physicians Conference	250,00		26.12		223.88
B- 9	For Journal Taxes—Pay Roll	200.00 133.00	114.39		200.00 18.61	E-14	Expenses— Exhibits and					220100
B-10	Refunds From Subscrip-						Displays	650,00		507.54		142.46
11.11	tions, etc.	30.00	2.09		27.91	E;-15	Publ'c Rela- tions Conference	500.00		110.63		389.37
	Publication of Roster	2,600.00	17.78		2,582.22	E-16	Physicians Press Conference	400.00		110.56		
B-12	Sales Tax—Journa Subscriptons and					E-17	Public and	400.00		110.56		289.44
m	Roster Sales .	520,00	377.67		142.33		Personified Activities	800.00		182.68		617.32
	Journal Budget\$ netional Activity Bu		\$ 50,841.48	\$ (5,898.48)	E-18	High School Essay Contest					
C- 1	Expenses—Executive Council	re	3 1,406.05	\$	1,093.95	E-19	Collateral Public					
C- 2	Expenses—			•		Total	Relations Public Relations	2,000.00		334.78		1,665.22
C- 3	Councilors Expenses—Legisla-	500.00	8.81		491.19	A		26,803.00			\$	7,305.88
C- 4	tive Committee Expenses—	1,500.00	541.79		958.21	F- 1	Sessions (104th) Co Programs\$	1,400.00			(\$	246,10)
	Maternal Welfare	0 000 00	0.000.14	,	1.100.101	F- 2	Hotel and Audi- torium Expense	2,500.00		1,797.74		702.26
C- 5	Committee Expenses—Cancer	2,800.00	3,998.16		1,198.16)	F- 3	Publicity Promotion and Expenses					
C- 6	Committee Expenses—		.51	(.61)	F- 4	Entertainment	325.00 775.00		240.77 532.58		84.23 242.42
	Convention					F- 5	Orchestra and Floor Entertainment	2,000.00		2,165.68	(156,68)
	Arrangements Committee		.10	(.10)	F- 6	Guest Speakers and Honorarium	800 00		271.63		628.37
C- 7	Expenses—Scien- tific Exhibits an	d				F- 7	Banquet Speaker	350.00		211.00		360.00
	Audio-Visual Committee	100,00	25.75		74.25	F- 8	Electric Amplification	100.00		162.00	(62.00)
C- >	Expenses-Mental	100,00	20.10		74.40	F- 9	Booth Installations and Supplies	4,000.00		4.103.23		103.23)
	Hygiene Committee	500.00	155.45		344.55	F-10	Projection				,	
C- 8	Expnses— Grievances					F-11	Expense Badges	500.00		$421.75 \\ 28.74$	(73 25 28.74)
6.10	Committee		2 1.98	(1.98)	F-12	Transaction Report ing Service	2,000.00		2,262.11		262.11)
C-10	Expenses—Coroner System					F-13	Rentals for Sections	3			,	
C-11	Committee Expenses—Commit-					F-14	and Exhibits Exhibitors	400.00		157.16		242.84
	tees in General Expenses—	2,000,00	1,987.46		12.54	F-15	Entertainment Banquet Expense	700.00 $5.000.00$		1,103.75 3,518.67	(403.75) 1,481.33
C-12	Anesthesia Study					Total	Annual Sessions (104th Conven-					
C-13	Committee Expenses—Occupa-	400,00	400.00				tion Budget -\$	20,850,00	\$ 1	8,401,91	\$	2,448.09
	tional Health Committee	100 00	318,05	,	218.05)	Miscellane	eous Budget:					
C-14	Expenses—Profes-	100 00	010.00	`	210.007		Previous Accounts Payable	100.00	\$		3	100.00
	sional Liability Insurance					G- 2	Refunds— Dues, etc	100,00				100.00
C-15	Committee Expenses—Child					G- 3	Legal Counsel	5,000.00		3,905.71		1,094.29
2-40	Health	0.000.00	005.10	,	# 4A)	G- 4	Reporting (Execu- tive Council,					
C-16	Committee Expenses—	918.00	925.10	l .	7.10)	G- 5	etc.)\$ President's Jewel	1,200.00 100.00	\$	805 69 117.77		394.81 17.77)
	Negotiations Committee	5,000.00	5,847.03	r	847.03)	Ğ- 6	General Practitioner				•	
Total	Intra-Functional	-,0000	5,011.00		5111007		of Year Fifty Year Club	60.00. 200.00		24.68 212.31	(35.82 12.31)
	Activity Budget\$	16,818.00	\$ 16,616.24	\$	701.76	G- 8	Section (12) Expense	225.00		47.28		177.72
Extra-Fu D- J	nctional Activity Br Expense of A. M. A.	udget:				G- 9	Contingency and Emergency	1,000.00				
	Delegates\$	2,535.00 200.00	\$ 2,295.27 29.50	\$	239.78	G-10	Organizational			785-11		214.89
1.7- 2	Conference Dues	200.00	29.50		170.60		Survey	500.00				. 500.00

G-11 Employees'	Expenditures—Public Relations Budget\$ 19,563.05 Less: Capital Expenditures—
Retirement System 2,600.00 3,961.86 (1,361.86)	Office Equipment 939.42 18,523.63
Total Miscellaneous Budget\$ 11,085.00 \$ 9,860.41 \$ 1,234.69 Rural Health Function Budget:	Expenditures—Annual Sessions (104th) Convention Budget
H- 1 Expense of Na- tional Conference	Expenditures—Rural Health Function Budget 9,643.12
Chairman\$ 300.00 \$ \$ 800.00 H- 2 Salary—Rural	Refunds of Dues Over Collected and 1,308.000 Not Accepted 1,308.000 Refunds of A. M. A. Dues in Escrow 362.50
Healtb Consultant 6,720.00 6,719.96 .06	Refunds—Miscellaneous
H- 3 Travel—Rural Health Consultant 2,000.00 1,270.71 729.29	Accrued Pay Roll Taxes 12-31-57
H- 4 Clerical Assistance —Part Time 1,240.00 1,270.00 (30.00) H- 5 Taxes—Pay Roll 164 00 149.88 14.12	Total \$189,929.92 LFSS: Deductions From Wages—
H- 6 Rural Health	Unpaid at 12-31-68 Pay Roll Taxes
Conference 600.00 339.42 260.68 H- 7 Office Expenses 700.00 661.12 38.88	Hospital Insurance 28.90 748.78 TOTAL DISBURSEMENTS FOR
H- 8 4-H Club Activities 400.00 389.96 10.06 H- 9 Educational Film 460.00 460.00	CURRENT OPERATIONS \$189,181.14 PAYMENTS TO AMERICAN MEDICAL ASSOCIATION—REGULAR DUES
Total Rural Health Function	COLLECTED
Budget\$ 11,674.00 \$ 9,801.03 \$ 1,772.97 TOTAL EXPENSES\$183,033.00 \$168,635.36 \$ 14,496.64	ASSETS 2,634.73 PAYMENT FOR SHIRLEY WILDS
SUMMARY: TOTAL INCOME \$177.986.93	SCHOLARSHIP 230.00 TOTAL DISBURSEMENTS \$268,966.87
LESS: EXPENSES: Executive Budget \$41.842.08	CASH BALANCE, DECEMBER 31, 1958: First-Citizens Bank and Trust Co.,
Journal Budget 60,841.48 Intra-Functional Activity Budget 16,618 24 Extra-Functional Activity Budget 3,188.09	Raleigb. N. C. \$ 6,196.06 Cash On Hand 994.78 6,189.83
	TOTAL ACCOUNTED FDR \$265,155.70 SCHEDULE—1
Annual Session (104th)	CASH ON HAND AND IN BANK
Rural Health Function Budget 9.801.03 168.636.36	December 31, 1958 FIRST-CITIZENS BANK AND TRUST COMPANY,
EXCESS OF INCOME OVER	RALEIGH, N. C.: Balance Per Bank Statement
LESS: CAPITAL EXPENDITURES FROM CURRENT FUNDS 2,634.73 NET INCOME FROM OPERATIONS—	LESS: Outstanding Checks: Number 7186 \$ 550.00
NET INCOME FROM OPERATIONS— TO EXHIBIT "B" \$ 6,914.84	7339 161.56 7496 450.00
EXHIBIT "D"	7497 6.00 1,267.66 BALANCE PER BOOKS \$ 6,195.06
CASH RECEIPTS AND DISBURSEMENTS 12 Months Ended December 31, 1968	PETTY CASH FUND 50.00 CASH ON HAND—Undeposited Receipts 994.78
RECEIPTS:	TOTAL—TO EXHIBIT "A"
CASH RECEIVED FROM REGULAR OPERATIONS:	
Members' Dues-Current and	INVESTMENT IN UNITED STATES BONDS
Prior Years	December 31, 1958
Prior Years \$103,914.00 Medical Journal Advertising—Local \$8,906.33 Medical Journal Advertising—National 41,182.84 Sale of Exhibit Space at 1968	December 31, 1958 DEFENSE BONDS—SERIES "F": Date of Date of Par Value Issue Maturity At Maturity Cost
Prior Years \$103.914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertising—National 41,182.84 Sale of Exhibit Space at 1968 11,266.00 Sale of Exhibit Space at 1969 11,266.00	December 31, 1958
Prior Yesrs \$103,914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertising—National 41,182.84 Sale of Exhibit Space at 198 11,266.00 Sale of Exhibit Space at 1969 8,466.00 State Convention—Escrow 8,466.00 Medical Journal Subscriptions and Sales 116.82	December 31, 1958
Prior Years \$103,914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertising—National 41,182.84 Sale of Exhibit Space at 1968 11,266.00 Slate Convention 11,266.00 State Convention—Escrow 8,466.00 Medical Journal Subscriptions and Sales 116.82 Sale of Rosters 293.84 Interest on United States	December 31, 1988
Prior Years \$103,914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertising—National 41,182.84 Sale of Exhibit Space at 1968 11,266.00 Sale of Exhibit Space at 1969 8,466.00 State Convention—Escrow 8,466.00 Medical Journal Subscriptions and Sales 116.82 Sale of Rosters 293.84 Interest on United States 2,118.40 Over Collection of Dues. 2,118.40	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
Prior Years	December 31, 1988
Prior Years \$103,914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertising—National 41,182.84 Sale of Exhibit Space at 1968 11,266.00 Sale of Exhibit Space at 1969 1,266.00 State Convention—Escrow 8,466.00 Medical Journal Subscriptions and Sales 116.82 Sale of Rosters 293.84 Interest on United States 293.84 Government Bonds 2,118.40 Over Collection of Dues 1,086.60 Commissions (1%) From A. M. A. 670.76 Micror Collecting Dues 670.76	December 31, 1988
Prior Years	December 31, 1988 DEFENSE BONDS—SERIES "F": Date of Date of Par Value Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost Mid4803F 4 - 1-50 4 - 1-62 \$1,000.00 \$740.00 X366930F 4 - 1-51 4 - 1-63 10,000.00 7,400.00 X366939F 4 - 1-51 4 - 1-63 10,000.00 7,400.00 X366929F 4 - 1-51 4 - 1-63 10,000.00 7,400.00 X472186F 3-31-62 3-31-64 10,000.00 7,400.00 C1855655F 3-31-62 3-31-64 10,000.00 7,400.00 C1855656F 3-31-62 3-31-64 10,000.00 7,000.00 C1855665F 3-31-62 3-31-64 10,000.00 C1855665F 3-31-64
Prior Years \$103,914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertisins—National 41,182.84 Sale of Exhibit Space at 1968 11,266.00 Sale of Exhibit Space at 1969 11,266.00 Siste Convention—Escrow 8,466.00 Medical Journal Subscriptions and Sales 233.84 Sale of Rosters 293.84 Interest on United States 293.84 Government Bonds 2,118.40 Over Collection of Dues 1,086.60 Commissions (1%) From A. M. A. 670.76 Miscellaneous 384.87 Miscellaneous Refunds— 44.00 Miscellaneous Refunds— 2.95	December 31, 1988
Prior Years \$103,914.00 Medical Journal Advertising—Local 8,906.33 Medical Journal Advertisins—National 41,182.84 Sale of Exhibit Space at 1968 11,266.00 Sale of Exhibit Space at 1969 11,266.00 Siste Convention—Escrow 8,466.00 Medical Journal Subscriptions and Sales 233.84 Sale of Rosters 293.84 Interest on United States 293.84 Government Bonds 2,118.40 Over Collection of Dues 1,086.60 Commissions (1%) From A. M. A. 670.76 Miscellaneous 384.87 Miscellaneous Refunds— 44.00 Miscellaneous Refunds— 2.95	December 31, 1988
Prior Years	December 31, 1988
Prior Years	December 31, 1988 December 31, 1988
Prior Years	December 31, 1968
Prior Years	December 31, 1988
Prior Years	December 31, 1988 DEFENSE BONDS—SERIES "F": Date of Date of Par Value Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost Mid4803F 4 - 1-50 4 - 1-62 \$1,000.00 \$740.00 X366930F 4 - 1-51 4 - 1-63 10,000.00 7,400.00 X366929F 4 - 1-51 4 - 1-63 10,000.00 7,400.00 X472186F 3-31-62 3-31-64 10,000.00 7,400.00 X472186F 3-31-62 3-31-64 10,000.00 7,400.00 C1855656F 3-31-62 3-31-64 10,000.00 7,400.00 C1855666F 3-31-62 3-31-64 10,000.00 C1855666F 3-31-64 10
Prior Years	December 31, 1968
Prior Years	December 31, 1988 DEFENSE BONDS—SERIES "F": Date of Date of Date of Date of Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost M1644803F 4 - 1-60 4 - 1-62 \$1,000.00 \$740.00 X356930F 4 - 1-61 4 - 1-63 10,000.00 7,400.00 X356930F 4 - 1-61 4 - 1-63 10,000.00 7,400.00 X472186F 3-31-62 3-31-64 10,000.00 7,400.00 X472186F 3-31-62 3-31-64 10,000.00 7,400.00 C1855656F 3-31-62 3-31-64 10,000.00 C1855666F 3-31-62 3-31-64 10,000.00 C1855666F 3-31-62 3-31-64 10,000.00 C185566F 3-31-62 3-31-64 10,000.00 C18566F 3-31-62 3-31-64 10,000.00 C185566F 3-31-62 3-31-64 10,000.00 C185566F 3-31-62 3-31-64 10,000.00 C185566F 3-31-62 3-31-6
Prior Years	December 31, 1968
Prior Years	December 31, 1968 DEFENSE BONDS—SERIES "F": Date of Date of Par Value Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost Mind
Prior Years	December 31, 1968 Defense Bonds—Series "F": Date of Date of Par Value Issue Maturity At Maturity Cost Issue Maturity At Maturity Cost Mind

One (1) Del Year	30.00		WWW. 14 W. 1
One (1) Desk Lamp Two (2) Master Model Audiographs	10.26		PUBLIC RELATIONS OFFICE: Four (4) Aluminum Desk Trays
and Attachments	725.67		With Supports \$ 9.00
One (1) Map of Greater Carolinas Two (2) Double Files 3" x 5"	37.50		With Supports \$ 9.00 Steel Costumer 14.20 Cost Roy 14.20
One (1) Remington Electric Deluxe	11.86		Cash Box 1,50 Supply Cabinet 37,00
Typewriter	337.90		Two (2) Waste Baskets 7.00
intee (5) rendariex	5.55		Metal Executive Desk 112.60
Frames (Installed)	5.57 103.00		Executive Chair 48.00
Two (2) Grey Steel Cabinets Three (3) Tranfer Files	11.89		Motel Segmeterns Deals 190 to
One (1) Spec. D. Outfit File	7.26		130,40 1
Two (2) Legal Filing Cabinets One (1) Filing Shelf	19.90 2.50		Storage Cabinet 37.00
Plywood	2.50		Two (2) Chair Mats 12.90 Hinge Top Card File 1.60
Carrying Case for Andiograph	17.00		Stapler 4.95
Map Framed Charter Framed	3.61		Funcii 3,10
Charter Framed Cash Box	2.57 2.79		Metal Letter File With Lock
Steel Desk	158.98		Storage Cabinet 37.00 Royal Typewriter 133.31
Three (3)			Two (2) Electric Fans 63.29
Desk Trays With Stackers Waste Basket	8.57		Four Drawer Metal File
Waste Basket	1,40 9,27		Two Drawer Metal File With Lock and Base 18.36
Large Chair Mat Glass Desk Top	11.68		Supply Cabinet 75.00
Sterograph and Tripod	100.70		Two (2) Desk Trays and Stacks 4.64
Four Drawer Steel Filing Cabinet Four Pendaflex Steel	78.03		Metal Storage Cabinet
Frames (Installed)	7.42		Fro Rata Share of
Postal Scale	6.50		Mimeograph Machine 508,53 Pendaflex Frames (Installed) 4.64
Numbering Machine	14.88		Folder Machine and A. B. Dick Stand 397.88
Filing Stool Bookcase	11,23 63,86		Used Elliott Addressograph
Remington Rand Electric Adding			Two (2) Telephone List Finders 6.06 Pendaflex Frame (Installed)
Machine	215.01		Verifax Printer Type I 247.20
Metal Storage Cabinet	78 25 92.76		Used Projector—Nadco 153.43
Two (2) Cabinet Shelves (Installed)	10.80		Model DLS Screen
Motal Carb Roy	2.32		Record Player 101.26 Microphone and Stand 19.40
Pro Rata Share of Cost of Mimeograph Machine Typewriter Table	0.05 45		Projector With Case—Slide 94.47
Typewriter Table	337.47 21.00		Lectern Mike 56,85
Metal Correspondence Separator	6.18		Display Equipment—Flip Chart
Metal File and Sections	68,55		Remington Electric Typewriter 430.55 One (1) Camera and Flash 88.98
Two (2) Typewriters—	321.23		Film Holders and Adapters 19,00
Two (2) Typewriters— Large Type (Bulletin) Kardex File and Parts	1.842.36		Metal File 95,79
	20,00		Pro Rata Share of Cost— Varityper—Used
Metal File and Frames	93.07		Pro Rata Share of Cost—
Electric Typewriter	$477.00 \\ 25.75$		A. B. Dick Offset Duplicator 1,602.26
Three (3) Transfer Files	16 23		Pro Rata Portion of Postage Mailing Machine 427,85
Junior Pendaflex File	22.87		Postage Mailing Machine 427.85 Pro Rata Portion of Robotyper 360.50
	26,25		Pro Rata Portion of Perforator 121.02
Remington Electric Typewriter Swivel Chair and Army Chair	290,30 74,48		Pro Rata Portion of One (1) Table 17.58
Audiograph Converter	28.84		Pro Rata Portion of Postal Scale 12.47 TOTAL
Audiograph Converter Pendaflex File	5.88		PUBLIC RELATIONS OFFICE \$ 6,044.91
Used Desk and (2) Files	281.43		JOURNAL BUSINESS MANAGER'S OFFICE:
De Jur Camera With Flash Attachment and Case	100,44		Steel File and Frame \$ 88.27 Pro Rata Share of Cost of Imperial Safe KD "60" (Kardex)
Audiograph Machine-Used	300.00		Pro Rata Share of Cost of Imperial
Audiograph Machine—Used Flight Bag Three (3) Box Files	38.31		Safe KD "60" (Kardex)
Three (3) Box Files	9.42		TOTAL JOURNAL BUSINESS
Portable Lectern Metal File	29 93 114.83		MANAGER'S OFFICE 264.69
Checkwriter—Paymaster	101.48		RURAL HEALTH AND MEDICAL
Transcriber	328,16		CARE COMMITTEE:
Dictating Machine Desk and Chair	$\frac{429.08}{268.45}$		Masco Tape Recorder \$ 159.18 One (1) Desk 185.40
Desk and Chair Supply Cabinet Shelves	25.35		One (1) Steel File and Trays 121.29
Pro Rata Share of Cost of Imperial			One (1) Soundscriber 150,00
Pro Rata Share of Cost of Imperial Safe KD "60" (Kardex) Air Conditioning Equipment—Office	290.00 1,621.00		TOTAL RURAL HEALTH AND MEDICAL
Five Drawer Letter File and Frames	122.78		CARE COMMITTEE
Remington Electric Typewriter .	347.98		Portable Lectern 29.67
Five (5) Transfer Files	20.35		TOTAL OFFICE FURNITURE
Two (2) Five Drawer Filing Cabinets American Medical Dictionary	$245.66 \\ 26.00$		AND FIXTURES \$ 23,310.25
Two (2) Plate Glass Tops for Desks	20.34		REAL ESTATE: Land—Durham-Raleigh Highway—
Desk, Swivel Chair and Desk Set	253.87		(Schedule—4) \$ 26,104.55
Remington Rand Electric Typewriter .	430.55		OTHER ASSETS:
Pro Rata Share of Cost— Varityper — Used	50.00		Capital Stock—State Medical Journal Advertising Bureau, Inc
Pro Rata Share of Cost—			TOTAL CAPITAL ASSETS—
A. B. Dick Offset Duplicator .— Ten (10) Pronto Files	1,602,27		TOTAL CAPITAL ASSETS— TO EXHIBIT "A" \$ 49,614.83
Ten (10) Pronto Files Two (2) Four Drawer	46.87		SCHEDULE—4
Durable File Cabinets	61.70		SCHEDULE OF BUILDING SITE COSTS
One (1) Kardex File Safe and Base	593.28		12 Months Ended December 31, 1958
Pro Rata Portion of	400 00		Options
Postage Mailing Machine*. Pro Rata Portion of Robotyper	427.85 360.50		Land Purchase— Durham-Raleigh Highway 24,660.00
Pro Rata Portion of Perforator	121.03		Legal Service 126.76
Pro Rata Portion of One (1) Table Pro Rata Portion of Postal Scale	18.47		Survey and Map of Property
TOTAL EXECUTIVE OFFICE	12.48	\$ 16,355.14	Architect Service
OITIEL .		,000.11	\$ 20,104,00

SPEAKER KOONCE: Mr. Hilliard's report is in the compilation.

PUBLIC RELATIONS ANNUAL REPORT

of William N. Hilliard May 4, 1959

Activities in the best interests of the Medical Society as an organization and a continued contribution to developments of benefit to the individual members has been our earnest endeavor during the past year.

Our actions have been guided by the policy decisions of the Committee on Public Relatinos. The members of that committee, Dr. E. T. Beddingfield as Chairman, and Dr. W. J. Senter and Dr. R. B. Garrison as members have been ever willing to assist and back our efforts whenever their advice was needed. Our sincerest appreciation to them for their generosity in time and effort in guiding our activities.

Your Executive Director, Mr. James T. Barnes, has frequently evaluated our projects and proposals and we are certainly deeply grateful for the opportunity of having the

wisdom of his advice.

We have endeavored to coordinate our work with that of Mr. Barnes and under his supervision have tried to assist and work with other committees of the Society wherever

possible.

A considerable amount of time was spent last fall by way of preparation for the Conference of County Medical Society Officers and Committeemen conducted in Pinehurst on January 10, 1959. This was an effort sponsored by the Committee on Public Relations to help orient newly elected County Society officials to their duties and responsibilities. Speakers were invited to numerate some of the problems facing medical organizations today and offer suggested solutions and some of the sources of assistance. Workbooks as reference material for the various County Society Officers were developed and distributed at that meeting. It is hoped that approval will be given for a similar undertaking in 1960.

During the period from September 22 to January 26, the responsibility of developing and coordinating a 30-minute television program on health topics for each Monday night over the University of North Carolina Educational Television Station. Channel 4 facilities, involved an indeterminable amount of time. Several physicians participated in this series making excellent presentations as a part of this health education undertaking.

The Committee on Public Relations has continued to encourage County Medical Societies to hold local get-together meetings between press representatives and officials of the County Medical Society for the purpose of discussions in the interest of "mutual understanding." Several counties have held such meetings and the results are reported to be very favorable in the stimulation of improved relations. We should remember that one of our most important "publics" is the information media and particularly so since they are important molders of public opinion.

A Medical Society sponsored exhibit was erected at the N. C. State Fair October 14-19, utilizing an exhibit on Poisons by Dr. J. Arena and another exhibit on Childhood Accidents by Dr. Barnes Woodall. The exhibit also offered a blood typing service whereby approximately 1,000 persons availed themselves of the opportunity to determine their blood group and RH factor and receive a pocket size identification card indicating this information. The Wake County Medical Auxiliary was particularly helpful in manning the exhibit booth and assisting in the registration of persons at the blood typing service. Members of the North Carolina Society of Medical Technologists contributed their time at the exhibit to do the blood typing.

Every County Medical Society, regardless of size should have a public relations program, as should every individual physician. Any public relations program to be effective must be in operation day in and day out and must deal with the little problems as well as the big ones. Public opinion does not change in a vacuum but as a result of the impact of events. Good public relations certainly fosters a concern for our actions before a time of trouble.

Support by the Committee on Public Relations for the North Carolina Academy of Science and its promotion work in behalf of High School Science Fairs has been continued this year. The Committee also invites one High School Science Fair winner to exhibit at the annual Medical Society meeting his work in the Biological Science division of the High School Science Fair program.

We have continued our efforts to assist County Medical Societies in obtaining film program material whenever requested, particularly in the area of the Medical-Legal series. The latest film in this series entitled "The Man Who Didn't Walk" has been shown before several North Carolina County Medical Society groups and it will continue to be available. The two previous films in the series, "The Medical Witness" and "The Doctor Defendant" continue available on request.

A volume of first aid posters appropriate

for placing on the inside of home medicine chest doors have been distributed at the Society's State Fair Booth as well as through 4-H Clubs and similar civic organizations. Other educational materials and pamphlets have been distributed in an effort to relate

medicine's story to the public.

The Headquarters Office of the State Society continues to serve as a distribution point for transcribed radio programs produced by the American Medical Association. Approximately 25 different series of programs of 15 minute program on medical and health topics are available for County Medical Society use over local radio stations. Each series or topic contains 13 of the 15 minute programs and have been well received by radio stations now using the programs as indicated by their comments and continuing requests for additional series. We have also arranged for the broadcasting of a weekly transcribed program entitled "Health Magazine of the Air," a news type program based on articles which have appeared in the AMA magazine Today's Health over approximately thirty stations throughout the state.

The two day Annual Public Relations Institute of the American Medical Association was attended in Chicago last August 27-28. In addition several other state and out-of-state workshop conferences have been attended in behalf of your State Society. Attendance at these meetings, we feel, has contributed to the "know-how" and offered an opportunity for your representatives to exchange ideas with others so employed in other states and who have confronted similar tasks for the medical profession to the end that a benefit is experienced by the individual State Society.

The Public Relations Bulletin has been edited with a desire to make it brief and newsworthy as an organ of the society for expeditiously reaching the membership with messages and information of importance. During 1958 it was distributed on an every other month basis or six issues annually. At the July 20 meeting of the Committee on Public Relations it was recommended that the Bulletin be distributed on a nine issues per year basis, or monthly except for the months of May, July, and August.

Statistical reference is made to the following tabulation with regard to the public relations mailings.

April 25, 1958 - March 20, 1959	
Mail Received	2,096
Mailed	6,543
Press Releases	664
Films	43
Radio Transcriptions	403

Pamphlets	115.284
Public Relations Bulletin	22.231
Long Distance Telephone Calls	210
Local Telephone Calls	1,300
/s/ William N. Hilliard	

/s/ William N. Hilliard Executive Assistant for Public Relations

SPEAKER KOONCE: I would like to announce that Dr. George Paschal has been designated as parliamentarian.

Next is the report of the Council as it

appears in the compilation.

FIRST DISTRICT:

The affairs of the First District have been harmonious during the past year. There has been only one complaint and this has been handled satisfactorily before the Grievance Committee of the State Medical Society.

We have just completed a series of six post-graduate lectures with good interest shown by the physicians in this and sur-

rounding areas.

We are pleased that the Seaboard Medical Society plans to have its meetings annually at the Carolinian, Nags Head, North Carolina, and that this next meeting, chock full of good speakers, will be held June 25th, 26th and 27th.

Our Officers for this year are Dr. Richard Hardin, Edenton, North Carolina, President; Dr. Ed Bond, Edenton, North Carolina, Sec-

retary-Treasurer.

/s/ T. P. Brinn, M.D., Councilor First District

SECOND DISTRICT:

It is my pleasure to report, as Councilor of the Second District, that the general status of professional deportment and harmony within my District, so far as I am aware, is excellent.

It might be noteworthy to mention, inasmuch as we are in close proximity to two large military installations, that Medicare went out with very little discussion or concern on the part of the physicians in this area.

I think I am justified in expressing the almost universal opinion of our physicians that they would prefer the State meeting moved from Asheville to a point more easily accessible to the eastern counties,

/s/ Wm. H. Bell, Jr., M.D. Councilor, Second District

THIRD DISTRICT:

The Councilor has attended each of the meetings of the Executive Council.

There have been no unusual problems within the district.. Harmony and good-will have been evident.

We had our annual meeting in the fall at

White Lake, with good attendance, and an excellent program.

At the request of the Grievance Committee, the Councilor investigated one (1) grievance. The problem was settled to the satisfaction of all participants concerned.

/s/ D. H. Bridger, M.D., Councilor Third District

FOURTH DISTRICT:

The fourth district suffered a profound loss during this Society year by the passing of Dr. Henderson Irwin, who at the time of his death was District Councilor. Dr. E. L. Strickland, District Vice-Councilor, resigned because of physical disability, and the undersigned was elected by the Executive Council to serve as District Councilor until the next Annual Session. Since accepting this responsibility, it has been my observation that in general peace and harmony prevail in our district. No serious problems have come to my attention, and the minor things that have arisen have been easily and quickly resolved.

/s/ Edgar T. Beddingfield, M. D.

Councilor

FIFTH DISTRICT:

As Councilor for the 5th District of the Medical Society of the State of North Carolina, I am happy to report that excellent harmony exists.

The 5th District had a full day meeting held at the Southern Pines Country Club. The meeting was well attended and an excellent scientific program was presented.

The cocktail hour was through the courtesy of Drug Products Company of Winston-Salem, North Carolina, and added much to the evening's pleasure.

All county societies in the District were contacted concerning the Polio Bill before the Legislature and also other necessary legislative support.

As Councilor, I attended the work shop meeting for newly elected county officers held at Pinehurst, North Carolina, sponsored by the Public Relations Committee of the State Society.

At present time, we are in the process of transferring Chatham County Medical Society from the 5th Medical District to the 6th at the request of the Chatham County Society. From the geographical position of Chatham County, I think this would be a logical move.

So far, I have been able to attend all executive council meetings to serve on the Polio Committee and attend all meetings of the Public Relations Committee.

/s/ Dr. Ralph B. Garrison, Councilor Fifth District SIXTH DISTRICT:

The Annual Meeting of the 6th Medical District was held at Durham, North Carolina, on October 20, 1958. This meeting was in conjunction with a meeting of the North Carolina Academy of General Practice. It was hoped that by combining the two meetings that our attendance would be increased. This did not prove to be the case. The outgoing Officers were:

Dr. Isaac H. Manning, Jr., Durham, N. C., President

Dr. P. Y. Green, Burlington, N. C., Vice-President

Dr. Hubert C. Patterson, Chapel Hill, N. C., Secretary-Treasurer.

The Officers elected for the current year were:

Dr. Joseph Combs, Raleigh, N. C., President

Dr. A. G. Crumpler, Fuquay Springs, N. C., Vice-President

Dr. James Manly, Raleigh, N. C., Secretary-Treasurer.

At the request of the Grievance Committee the Councilor investigated a single complaint against one of our members. This grievance was settled amicably and to the satisfaction of all concerned.

Upon request the Council nominated five doctors, three of whom were appointed, to a committee to represent this district in Blue Shield affairs. These members are:

Dr. Isaac E. Harris, Jr., Durham, N. C. Dr. William J. Senter, Raleigh, North Carolina

Dr. Alexander W. Simmons, Burlington, N. C.

The Councilor attended and participated in the program of the 6th District Community Health Conference sponsored by the Medical Society of the State of North Carolina Committee on Rural Health and Education held at Butner Training School Auditorium on January 21, 1959. He spoke a word of welcome and outlined the history and purposes of the Committee on Rural Health and Education. The meeting was well attended and audience participation was exceptional.

The Councilor has attended each of the meetings of the Executive Council. No unusual problems have been presented.

usual problems have been presented.
/s/ George W. Paschal, Jr., M.D.
Councilor, Sixth District

SEVENTH DISTRICT:

The Seventh Distrist thus far has had a very fine year.

One of the best District Medical Society Meetings we have ever had was held in Concord on October 22, 1958. At this meeting we had a delightful program which included (1) "Staphylococcal Infections" by Dr. Ivan L. Bennett, Jr., Johns Hopkins University, Baltimore, Maryland; (2) "Fats, Diets, and Atherosclerosis" by Dr. Jules Hirsch, Rockefeller Institute, New York, New York, At the night meeting we had a very pleasing address by Dr. Ralph F. Bowers, Chief of Surgery, Veterans Administration Hospital, Memphis, Tennessee, on "Some Remaining Controversies in Biliary Surgery."

The following officers were elected at the meeting in Concord on October 22, 1958:

Dr. Fred T. Craven, Concord, N. C., President

Dr. Vernon L. Andrews, Mt. Gilead, N. C., Vice President

Dr. Charles Highsmith, Troy, N. C., Secretary-Treasurer.

Members of the Montgomery County Medical Society will act as a group in preparing the next meeting of the Seventh District Medical Society in October 1959.

Your Councilor has been quite busy with the activities of the Seventh District. We have had only a few minor grievances submitted to us and these have been handled on a local basis.

We are very grateful indeed to the medical profession of Cabarrus County and particularly to Dr. Ladd Hamrick, Dr. Fred T. Craven and Dr. E. M. Tomlin for preparing such a fine program for us last October.

/s/ Claude B. Squires, M.D.

Councilor

EIGHTH DISTRICT:

We had a good meeting of the Eighth District Medical Society in Elkin October 23rd. Between 170 and 180 doctors and their wives attended.

We had an excellent afternoon program with a well attended banquet and after-dinner speaker.

The business session of the Society has recommended, voted on, and carried that we would ask the County Societies of the District to collect a dollar per year from each member of each district. This information was sent to the officers of the county societies, and most of the county societies, and most of the county societies have agreed to make this collection and turn it over to the Vice-Councilor, Dr. Harry Johnson, in January of each year. This money will be used to help defray expenses of the local societies when they are host to the Eighth District Society,

Several investigations for different committees of the Society were made by the Councilor and Vice-Councilor. Recommendations for committee appointments were made, and I am glad to report that we found

nothing of consequence in the investigations made.

s' Dr. M. D. Bonner, Councilor Eighth District

NINTH DISTRICT:

The past year in the Ninth Medical District has been quiet with no problems save some misunderstanding at the Davie County Hospital between the members of the staff and the Board of Trustees of the Davie County Hospital. The problem arose in large part as the result of personality differences between one member of the staff and the remainder of the staff .It was largely dissipated when this member left the staff and the State. At the request of the Rowan-Davie Medical Society Dr. Mees' Committee on Hospital and Professional Relations met with the staff and with the Board of Trustees and helped them in settling their differences. We were grateful for their help.

The annual meeting of the Ninth District Medical Society was held in Salisbury on Thursday, September 25th, where a scientific program, a cocktail hour, and a dinner were held. The after-dinner speaker was Dr. George Baylin of Duke University. The officers elected for the Ninth Medical District for next year are: President, Dr. Dan Stewart; Vice-President, Dr. John Lafferity; Secretary-Treasurer, Dr. Walter Leonard. The meeting next year will be held in Hickory.

/s/ Dr. Thomas L. Murphy Councilor

TENTH DISTRICT:

There are no matters of importance to report from the Tenth District. I would like to again report that our Fall Symposium held in Asheville on October 15, 1958, was a huge success. Our Committee on Arrangements had a most excellent program, that was well attended from every county in the District. The program, was made up of five (5) distinguished speakers, two in the morning and three in the afternoon, and the annual banquet at night in the George Vanderbilt Hotel. Some 200 attended and enjoyed every minute of it.

Our Spring meeting in April was held in Hendersonville in April with local members presenting the program, from over the district. This was a most excellent program and which shows conclusively that we have some excellent men right in our own back yard.

I have been urging our younger men to join their county societies and the State Society.

I know of no friction or disputes in our District.

/s/ W. A. Sams, M.D. Councilor, Tenth District

(The Speaker then called on each District in turn to see if it had anything to add.)

DR. SAMS: Just a correction in the report. Our spring meeting was held in Hendersonville. I understand that in the report it said it was held in Waynesville.

SPEAKER KOONCE: Next for action is the report on candidates for General Prac-

titioner of the Year.

The first is Dr. W. T. Turlington, Jr., from Onslow County; Dr. Westor Ghio Suiter, of Weldon, Halifax County; and Dr. A. F. Fortune of Guilford County.

There are three candidates now nominated for General Practitioner of the Year. You all have ballots, and we request you vote for one. And I would like to appoint Dr. Millard Hill as Chairman of the Teller Committee, with the help of Dr. Strosnider and Dr. Wayne Benton. They will collect the votes and count them and bring them back.

I have just been informed that I should have had approval, or acceptance, of the reports of the Secretary, Executive Secretary, and the Executive Assistant. Do I hear a motion that those three reports be ap-

proved?

DR. SMITH (Guilford) I so move.

(The motion was seconded, was put to a

vote and carried.)

SPEAKER KOONCE: May we also get acceptance of the report of the Councils as they are in your compilation? Do I hear a motion to that effect?

DR. STROSNIDER: I so move.

(The motion was seconded by Dr. Smith of Guilford, put to a vote and carried.)

SPEAKER KOONCE: While those ballots are being collected, we will go to "Report of Delegates of A.M.A." Dr. Faison, will you make a report on that?

(Dr. Faison indicated that there was nothing to add.)

REPORT TO THE NORTH CAROLINA MEDICAL SOCIETY OF THE MEETING IN SAN FRANCISCO JUNE 23-27, 1958 AND THE MEETING IN MINNEAPOLIS **DECEMBER 2-5, 1958:**

The meeting was called to order in the Sheraton-Palace Hotel June 23, at 10:30 a.m. by the Speaker of the House, Dr. E. Vincent Askey. Dr. David B. Allman, retiring President of the AMA, made an excellent ad-Dr. Gunnar Gunderson, President-Elect of the AMA, also made an impressive address. The latter is the 112th President of the AMA.

More than 60 resolutions were referred to the proper committees, and on Tuesday, the resolutions were considered. Wednesday morning, June 25, the next general session was held. At this time the resolutions were considered, which considerations were carried on until 4:30 p. m., Thursday, June

One of those resolutions, Number 20, declared that "a broad educational program be instituted at once by the American Medical Association to inform the general public, including the beneficiaries of the Fund, concerning the benefits to be derived from preservation of the American right to freedom of choice of physicians and hospitals as well as observance of the "Guides to Relationships Between State and County Medical Societies and the UMWA Welfare and Retirement Fund" adopted by this House last June. Another resolution, Number 24, called for the appropriate AMA committee or council to engage in conference with third parties to develop general principles and policies which may be applied to their relationships with members of the medical profession.

In explaining its position that final action on the two resolutions should be taken only after proper study, the reference committee said it "anticipates that the final report of the Committee on Medical Care Plans will contain recommendations serving to clarify the relationships between the medical profession, the patient and third parties, and the committee has been urged and assured that this can be expected." The committee also urged the Commission to present its recommendations no later than December 1958.

The House of Delegates, however, by a vote of 110 to 72, adopted a floor amendment "that this section of the Reference Committee report be amended to show that our AMA Headquarters Staff is directed, under supervision of the Board of Trustees, to proceed immediately with the campaign which was originally ordered at Philadelphia last December, that no further delays will be tolerated, and that the Council on Medical Service be relieved of any further responsibility in this matter.'

In considering seven resolutions dealing with the inclusion of self-employed physicians under the Social Security Act, the House disapproved of three which called for polls or a referendum of the AMA membership, one favored state-by-state participation in Social Security system.

On the question of polls, the House expressed the opinion that any poll should be taken on a state-by-state basis and the results transmitted to the AMA delegates from that state. It also pointed out that since there is no provision in the Constitution and By-Laws for a referendum of members, such

referendum would usurp the duties and prerogatives of the House of Delegates, which
is the Association's policy-making body. Concerning the voluntary health organizations,
there was a great deal of discussion. The
committee recommended that the Board of
Trustees meet with the officials of the Voluntary Health Organizations and officials of
the United Community Funds and endeavor
to work out a solution that was amicable to
all parties. However, an amendment was offered from the floor that passed after much
discussion. It is quoted below:

"1— That the House of Delegates reiterate its commendation and approval of the principle voluntary health agencies.

"2— That it is the firm belief of the American Medical Association that these agencies should be free to conduct their own programs of research, public and professional education and fund raising in their own particular spheres of interest.

"3— That the House of Delegates respectfully requests that the American Medical Research Foundation take no action, which would endanger the constructive activities of the national

voluntary health agencies.

"4— That the Board of Trustees continue actively its studies of these perplexing problems looking forward to their ultimate solution."

Concerning the Medicare Program, the House reaffirmed the action taken last year in New York recommending that the decision on type of contract and whether or not a fee schedule is included in future contract negotiations should be left to individual state determination. It also reaffirmed its contention that the Dependent Medical Care Act as enacted by Congress does not require fixed fee schedules; the establishment of such schedules would be more expensive than permitting physicians to charge their normal fees, and fixed fee schedules would ultimately disrupt the economics of medical practice.

A resolution was submitted and passed requesting the Board of Trustees to make an immediate survey and re-evaluation of the "functions and effectiveness of the over-all AMA legislative system, including the Washington office, in the light of present-day needs of the government, public and medical profession alike for effective liaison between government and medicine on all matters affecting the public's health and adequate, prompt and accurate transmittal to the full membership of the AMA of information on all current public issues in which the physician has a direct interest." The House asked

that the Board of Trustees implement, as rapidly as possible, all changes and additions that its survey discloses are desirable to achieve the basic purpose of the resolution, "effective public and government relations."

A report by the Council on Mental Health regarding medical use of hypnosis was approved by the House. The report urged physicians and dentists to participate in high level research on hypnosis and it vigorously condemned the use of hypnosis for entertainment purposes.

The House endorsed recommendations by

the Public Relations Department that:

The AMA join with other interested groups in setting up an expanded voluntary program coordinated by the National Better Business Bureau, which will work to eliminate objectionable advertising of over-the-counter medicines.

The AMA counsel with the National Better Business Bureau in the selection of a

physicians' advisory committee.

The established facilities of the AMA such as the Chemical Laboratory, the offices of the various scientific councils, and the Bureau of Investigation, be made available, so far as is feasible, to aid in the carrying out of this program.

With regard to the Veteran's Medical Care it was pointed out that the Federal Government spent \$619,614,000.00 during the year of 1957 on hospitalized veterans and VA hospitals. About 75% of these had non-service-connected disabilities.

The House adopted amendments to the constitution and by-laws eliminating the separate offices of Secretary and Treasurer, combining them into one, with a change of the titles of the General Manager and Assistant General Manager to Executive Vice-President and Assistant Executive Vice-President.

The House paid tribute to the Federal Food and Drug Administration in its efforts to safeguard the public and the profession and urged all states to review and strengthen their food and drug laws. The House requested that any funds provided under the Public Assistance provisions of the Social Security Act for medical care of the indigent be administered by a voluntary agency such as Blue Shield on a cost plus basis or by a specific agency established by the Medical Society of the State in which indigent care is rendered.

The House of Delegates was asked to give full consideration to the preliminary report of the Committee on Preparation for General Practice and to submit comments and suggestions to that committee. The House approved a National Interprofessional Code for physicians and attorneys to be prepared by the committees of the American Medical Association and the American Bar Association.

In conclusion Dr. Louis M. Orr was unanimously elected President-Elect for the ensuing year. Dr. W. Linwood Ball of Richmond, Virginia, Vice-President; Dr. E. Vincent Askey of Los Angeles, re-elected Speaker; and Dr. Norman A. Welch of Bos-

ton, Vice-Speaker.

The House approved a Board of Trustees announcement that Miami Beach will replace Chicago as the place of the 1960 Annual Meeting, and New York will be the site of the 1961 meeting. Action was postponed on selection of the city for the 1962 Annual

Meeting.

Rising votes of appreciation were given to Dr. Hamilton; Dr. George F. Lull, retiring secretary; and Dr. J. J. Moore, retiring treasurer. At the Wednesday session of the House an Illinois State Medical Society representative made another record state society contribution in its behalf to the American Medical Education Foundation by turning over a check in the amount of \$177,500.00 to Dr. Lull, now Foundation President.

TWELFTH CLINICAL MEETING — DECEMBER 2-5, 1958 — MINNEAPOLIS

The House of Delegates went into official session on Tuesday, December 2, at 9:00 A. M. in the Leamington Hotel in Minneapolis, Minnesota. Dr. Gunner Gunderson of La-Crosse, Wisconsin, AMA President who was speaking at this opening session, called upon the medical profession to exert leadership and imagination in meeting the problems of our changing times. He urged that we be practical in solving medico-economic problems. He declared that "the time has passed for policies based on generalities, platitudes, and flag-waving." He also urged that we support the proposals for an International Medical Year.

At this meeting, Governor Orville L. Freeman of Minnesota addressed the House of Delegates and urged that we continue strenuously to work out a program for the support and health care of our older citizens. He pointed out that this is becoming more and more a problem and that the eyes of the nation are searching us for a solution to the ever increasing problem. In response to the plea by Governor Freeman for help in meeting the health care needs of the aged, the House of Delegates adopted the following proposal submitted by the Council on Medical Service and endorsed by the Board of Trustees:

"For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance of prepayment plans in a way that would be acceptable both to the recipients and the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.

Therefore, the Council on Medical Service recommends to the House of Delegates, the adoption of the following proposal: 'That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate.'

The House then directed that copies of the proposal be sent.

The House decided to defer the action on the report of the Commission on Medical Care Plans until the June, 1959 meeting. In doing so, the following statement was adopted:

"We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following basic points.

'1— Free Choice of Physician — Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

2— Closed Panel System—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?"

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support that highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

It was then requested by the House that the constituent associations forward their replies to the Executive Vice-President 60 days in advance of the June meeting.

Regarding Osteopathy, there was a resolution which would have given the right of constituent medical associations to establish the relationship of the medical profession to the osteopathic profession within their respective states. This resolution was rejected and the Judicial Council was requested to review pronouncements of the House of Osteopathy and the status of the laws of the various states in this regard. It was recommended that this report be brought before the House at the June meeting. The House "noted with favor that the American Osteopathic Association has amended its objectives as stated in its constitution by deleting reference to the cultism of Andrew J. Still." With regard to the Medical Education and Hospitals, the House issued a statement in support of the development of the additional facilities for basic medical education, and it urged our profession to give this policy strong support in order to correct misinterpretations of the Association's viewpoint regarding the supply of physicians. This, the House approved, and the following statement was brought out:

American medicine, "the statement points out, "fully recognizes the needs being brought about by the increasing population, social and economic trends, and the changing dimensions of medical knowledge and its application. careful analysis of those needs, the statement says, that existing medical schools should consider the possibility of increasing their enrollments and developing new facilities." It also declared, "that American medicine has the responsibility to encourage the creation of new four-year medical schools and two-year basic science programs by institutions of higher education which can provide the desirable setting."

In considering the recent restrictive changes in the Medicare program the House expressed regret at the substitution of Federal facilities for private care in the areas mentioned, and urged the Association to encourage the re-establishment of services under the free choice principle to accomplish the original act. It recommended that the Social Security Act be amended by Congress to permit states to combine the present four Public Assistance medical programs into a single medical program, to be administered by a single agency and making available uniformity of services to all eligible

Public Assistance receipients in the state. It further authorized the Council on Medical Service to sponsor at the earliest practicable date a Congress on Prepaid Health Insurance.

The House of Delegates approved a plan to develop a "Buyers' Guide" which will be sent to physicians to help their patients analyze the merits of available health insurance programs. It further approved a By-Law amendment which will allow dues exemptions for interns and residents serving a training period program approved by the Council on Medical Education and Hospitals. It was called to the attention of all individuals or institutions responsible for internand resident training that medical services provided to patients in hospitals are the responsibility of duly licensed physicians.

The House encouraged the voluntary registration of the paramedical personnel who assist physicians, but opposed the extension of governmental licensure and governmental registration at this time.

The House heartily approved and lauded the purpose, content, and format of the *AMA News*, and recommended continuance of the publication under its present and established policies.

Concerning fund raising, a resolution was passed requesting the Board of Trustees to arrange a top-level conference with the voluntary health agencies, the United Funds and other partied interested in the raising of funds for health causes. This was done in the hope that misinterpretations and other difficulties in this area might be resolved.

The administrative structure of the Association was approved by the House. The Chicago staff has been divided into the following seven divisions:

1—Business Division 2—Law Division

3—Communications Division

4-Field Division

5—Division of Scientific Publications

6—Division of Socio-Economic Activities

7—Division of Scientific Activities

The Washington Office has also been reorganized with overall direction coming from headquarters office.

The House also recommended that the Board of Trustees establish a mechanism which will assume the responsibility for promoting active liaison with each national medical society. It also pointed out that in the scientific fields, the role of the AMA should be primarily that of leadership. The House also agreed with the Committee on Medical Practices that relative value studies

should be conducted by each constituent medical association but not on a national or

regional basis by the AMA.

It further urged each constituent society to establish a committee on rehabilitation to carry out activities recommended by the Board of Trustees. The House called for continued activity at all levels to stimulate the development of effective poliomyelitis inoculation programs and it also suggested that the Association take immediate steps toward developing a plan whereby reserve medical units and individuals not immediately involved in military operations, could be used to supplement Civil Defense Operations, and lastly, the House expressed gratitude and appreciation for the long years of devoted service by Dr. Austin Smith, who has resigned from his position as Editor of the Journal of the American Medical Association.

/s/ Dr. C. F. Strosnider Dr. Millard D. Hill

Dr. Elias S. Faison, Secretary

SPEAKER KOONCE: Do I hear a motion to approve the report of the Delegates to the American Medical Association?

DR. SMITH (Guilford): I so move. (The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: "Report of Related Organizations," there is first the report of the North Carolina Board of Medical Examiners, and there obviously is nothing to add. Do I hear a motion that it be accepted? DR. SHUFORD: I so move.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

ANNUAL REPORT OF THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA

February 1, 1958 - February 1, 1959 The State Board of Medical Examiners presents to you ,the State Medical Society, the annual report on its activities.

RE: Biennial Registration—The biennial registration was completed and a roster compiled, which was mailed to all registrants in the fall of 1958. The total registration to date is 5,325, which includes 695 licentiates living outside of North Carolina.

The members of your Board are as follows:

J. B. Anderson, M. D., Asheville—Examiner in Obstetrics and Gynecology

Thomas W. Baker, M. D., Charlotte—Examiner in Pharmacology, Pediatrics and Hygiene

Joseph J. Combs, M. D., Raleigh-Examiner in Pathology and Bacteriology L. Randolph Doffermyre, M. D., Dunn-Examiner in Physiology and Chemistry Edwin A. Rasberry, Jr., M. D., Wilson—Examiner in Medicine and Therapeutics Thomas G. Thurston, M. D., Salisbury— Examiner in Anatomy, Embryology, and His-Carl V. Tyner, M. D., Leaksville—Examiner in Surgery. Total number of applicants granted license
By written examination 206 By endorsement of credentials 123 Limited License Hospital residents _____59 Limited county or counties ____6 Borderline practice 3 Until citizenship obtained 6 Limited license converted to full license. 11 Special limited license _____86 Hospital residents _____40 Postgraduate foreign exchange residents 40 Staff state institutions 6 Written examination failure _____ 17 Part I 0 Part II 17 Applicants rejected license by endorsement Failure to meet Board requirements 2 Applicants declined permission to take written examination Hearings ______7 18 Narcotic addition—probation follow-up ______1 Petition reinstate medical license.... 3 Petition recommend issuance of narcotic license Petition recommend reinstatement narcotic license Violation of probation $\overline{1}$ Violation narcotic law _____2 Mental incompetency 1 Investigation State Bureau of Investigation _____ 6 8 Narcotic addiction — probation follow-up ______1 Violation narcotic law ______1 License revoked _____ 5 Convicted Federal Court—violation narcotic law _____1 Convicted Superior Court criminal abortion _____1 Mental incompetency _____1 Convicted Superior Court violation narcotic law judgment suspended _____1

Narcotic addition—judgment	
suspended 1	
Narcotic license surrendered 2	
Narcotic addiction 2	
Under surveillance of the Board 3	
Narcotic addiction 3	
License reinstated 0)
Recommendation that narcotic license be	
reinstated 2	
Declined petition for reinstatement	
medical license	
Petition to approve narcotic license	
declined 1	
Declined petition for reinstatement	
narcotic license 0	
's Thomas W. Baker, M. D.	
President	
Joseph J. Combs, M. D.	
Secretary-Treasurer	
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SPEAKER KOONCE: Next is the report of the North Carolina Hospital Saving Association.

DR. SMITH (Guilford): I move it be approved.

(The motion was seconded, was put to a vote and carried.)

REPORT FROM HOSPITAL SAVING ASSOCIATION TO

HOUSE OF DELEGATES MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

E. McG. Hedgpeth. M. D. Medical Director Hospital Saving Association has made an excellent 1958 record. In view of the fact that 1958 was a year of some business slowdown, increased hospital costs, and continued high incidence of hospital admission. Mr. Crawford and the staff of Hospital Saving Association deserve much credit for successful management and good administration.

These are the figures:

These are the figur	es.	
	1957	1958
Assets	\$5,372,534	\$6,147,461
Legal and		
Operating Reserv	re 2,727,610	3.024,183
Administrative &		
Sales Expense	10.6 ℃	9.5%
Surgical & Medical		
Participants	508,129	514,366
Doctor Payments	20 410 000	30.005.000
(Surg. and Med.)		\$2,627,360
Number Claims	89,395	95.087
Hospital Participan Hospital Payments	ts 530,470 \$8,128,988	535,306 \$9,070,628
Number Admission		85,432
Number Hospital D		515.800
Hospital Adm. Per	a, a 402,040	919,000
1,000 Members	159	161

National Blue Cross
Adm. Rate
137
140
In addition the Association paid slightly over a million dollars to North Carolina hospitals and over a million and a half to North Carolina doctors under the Medicare Pro-

gram administered by the Association.

During 1958 the Association made rapid progress in sale of Catastrophic type coverage, particularly "Extended Benefits" which provide coverage for many non-hospitalized

medical services.

Changes in the Doctors Program made by the House of Delegates in May, 1958, have been accomplished by the Association. The Blue Shield Committee has effectively carried out its many authorities and responsibilities. Members of the Blue Shield Committee and particularly its Chairman, Dr. Jacob H. Shuford of Hickory, have devoted much energy and time to Blue Shield matters at personal sacrifice. Enrollment of over 100,000 persons under the higher allowances of the Doctors Program Surgical Schedule, and an increase in the number of participating physicians indicate that this Committee has successfully resolved many complex problems in development of a program of benefit to the people of the state and their doctors. Dr. John C. Reece, President-Elect, has attended almost all Board meetings and meetings of the Blue Shield Committee. He will begin his Presidency with a fine background of information on current Blue Cross and Blue Shield matters.

During 1959 the Association will without doubt make Blue Cross and Blue Shield enrolment available to persons over 65. We are deferring action until after the Annual Meeting of the Medical Society to see if the Society wishes to sponsor a program of reduced fees for older persons of limited income, as recommended by the AMA to combat Forand type legislation. It should not be overlooked the Blue Cross and Blue Shield, both in North Carolina and nationally, have for twenty years continued protection for subscribers, regardless of age, if they secured coverage prior to age 65; well over three million senior citizens in the country are thus protected.

During the past year 32 new Grange groups were enrolled for an increase to 10,804 participants. Enrollment among Farm Bureau groups increased by 3,666 to a total of 14,044 participants. Non-group enrollment also improved.

In my report last year I stressed the problems and dangers of North Carolina's high incidence of hospitalization. I regret to say this did not improve in 1958, in fact, it became worse as the following figures show:
Increase '58 over '57

Membership .4%
Hospital Admissions
Blue Cross Income 9.3%
Blue Cross Claim
Payments 16.1%

To meet this problem on a sound financial basis, the Board of Trustees, with approval of the Commissioner of Insurance, established a rating pattern for 1959 that will determine Blue Cross membership rates according to usage within large groups or usage within a county for small groups. Blue Shield rates are not affected by this formula. However, it means that there may be more local public concern about the cost of Blue Cross protection. Communities with efficient and economical use of hospital facilities will no longer support high costs in other areas.

Respectfully submitted, E. McG. Hedgpeth, M. D., Medical Director Hospital Saving Association

SPEAKER KOONCE: At Dr. Hill's request, are there any more ballots that have not been collected? There are no further ballots. The ballots for General Practitioner of the Year as closed.

Next is the report on the A.M.E.F.

Do I hear a motion that it be accepted?

DR. KERNODLE (Burlington): I so
move.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Report of the Members of the North Carolina Medical Care Commission, Dr. J. Street Brewer who, unfortunately, is not here. Do I hear a motion to accept?

DR. POTEAT: I so move. (The motion was seconded.)

(The motion was put to a vote and carried.)

REPORT TO THE HOUSE OF DELEGATES OF THE NORTH CAROLINA MEDICAL SOCIETY BY THE THREE PHYSICIAN MEMBERS REPRESENTING THE MEDICAL SOCIETY ON THE NORTH CAROLINA MEDICAL CARE COMMISSION

The physician members nominated by the Medical Society as its representatives on The North Carolina Medical Care Commission are pleased to summarize as follows the accomplishments of the Commission to date and to report briefly on its future objectives.

Construction of Hospitals and Medical Facilities

The Commission has participated in a total of 294 projects to provide improved medical facilities for the State involving a cost of approximately \$129 million. Toward the cost of these projects, the Federal Government has contributed 42%, the State 14% and 44% has been subscribed by the local project sponsors. The projects are listed as follows:

1011011011	
General Hospitals	142
T. B. Hospitals	2
Mental Hospitals	7
Nurses' Residences	43
Health Centers	82
Outpatient Departments	8
Chronic Disease Facilities	5
Rehabilitation Facilities	5

Of this number, 252 projects have been completed, 19 are under construction and 23 are in the planning stage. The hospital projects involve a total of 8,067 beds, of which 745 are in State-owned institutions. There are now 42 projects involving a total cost of approximately \$33 million that are either under construction or in the planning stage.

The Commission has continued to emphasize construction of chronic disease facilities. To date 347 beds have either been completed, are under construction or in the planning stage. While this may seem rather slow progress, it is interesting to note from the latest figures available that North Carolina ranks second among the states in the development of chronic disease beds under the Hill-Burton program.

North Carolina now ranks first in the number of total projects under the Hill-Burton Act, fourth in the number of beds, second in the number of public health centers, first (together with several other states) in the development of rehabilitation facilities, ninth in the total funds expended and fifth in the amount of Federal funds allocated. The one area in which North Carolina is not distinguished is in the development of nursing homes under the Hill-Burton program. Thus far, no sponsors for this type of facility have applied for aid.

Programs for Licensing Hospitals and Nursing Homes

The Commission's work of licensing hospitals has involved the approval of approximately 168 hospitals and clinics that provide beds for the overnight care of patients. The licensed hospitals provide 14,756 beds.

The program for licensing nursing homes is now gaining impetus. The Commission has insisted on not licensing hazardous buildings and, therefore, has proceeded slowly as a means of encouraging the development of approvable physical plants as well as acceptable procedures in providing skilled nursing care for convalescent patients. Under this program, 18 nursing homes have been licensed, representing 10 additional facilities over those reported last year. A dozen or more are in the planning stage to be financed under private auspices. Altogether 544 approvable beds have now been licensed.

Hospitalization of the Medically Indigent
The Commission continues to provide
through appropriations of \$325,000 annually
contributions to hospitals toward the care
of medically indigent patients. Approximately 18,000 claims are processed annually,
representing over 200,000 days of care to
130 hospitals from all of the 100 counties, or
about \$18.00 per hospital admission based

on \$1.50 per patient per day.

The Commission is hopeful that the 1959 Legislature will enable it to increase this per diem to \$2.50 per day to allow for increased costs of hospitalization.

Student Loan Programs

The Commission's program for providing loans to worthy students of medicine, dentistry, pharmacy, nursing, psychology and sociology who will agree to practice either in small rural communities or in one of the state-owned mental hospitals for designated periods has involved the approval of 157 students under the rural program and 17 under the State hospitals program. At present 23 students of medicine, 6 students of dentistry. 2 students of pharmacy and 1 student of nursing have completed their training and are now practicing in rural areas of the State. There are 20 physicians who have completed their professional studies and will be available for rural practice as soon as their internship is completed or when they have served the required two years of military service.

It is expected that other students now in academic training, internship or serving in the armed services will be available for rural or State hospital practice within a short time.

While the Commission has made phenomenal progress, we think, in improving North Carolina's hospital facilities, the State's general and chronic disease hospital needs have not nearly been met. There is not only evidence that from 4,000 to 5,000 more general beds are needed, but there are between 2,000 and 3,000 existing beds which need to be replaced, many of which being situated in hazardous buildings will require complete abandonment as resources make this possible. The greatest evidence the

Commission has of the need for additional hospital beds and improved facilities is that it is serving today more projects involving more total costs than ever before in its twelve-year history. Presently, the Commission is responsible for processing 42 active projects involving a total cost of about \$33 million. Moreover, based on interest indicated by local hospital authorities, there is the prospect of projects developing within the next two years considerably beyond any reasonable probability of funds becoming available to finance them.

s J. Street Brewer Wm. Coppridge, M. D. Harry L. Johnson, M. D.

SPEAKER KOONCE: Now the report of the Committee on Constitution and By-Laws. Dr. Roscoe D. McMillan.

DR. McMILLAN: Mr. Speaker, Mr. President, Members of the House of Delegates, your Committee on Constitution and By-Laws wishes to make the following report. I will say that these changes were recommended at a meeting on Saturday. I shall first read the provisions of the Constitution:

At the May 5, 1958 meeting of the House of Delegates Article IV, Section 6, was amended to read: "Life Members shall consist of those physicians who have been members of the Society consecutively for 20 years and who have attained the age of 70 years. They shall be exempt from all dues and assessments and shall be entitled to all the privileges enjoyed by active members in good standing except the privileges of holding office and receiving the Journal. The time of a member's service in the Armed Forces of our country except on a career basis shall be considered as continuous membership in the Society."

I now report this amendment to the Constitution has lain on the table a year and I move it be adopted.

(The motion was seconded by Dr. Smith of Guilford.)

SPEAKER KOONCE: Is there any discussion? If not, all those in favor let it be known by saying "aye"; opposed "no."

(The motion was carried.)

DR. McMILLAN:

Amend Article VIII, Section 3. It appears to the Committee that the language in Article VIII, Section 3 is inconsistent with the language in other sections of the Constitution. Therefore, to cause conformity, the Committee recommends this amendment: Strike out in line 14 of Section 3 the word "active" from the last

sentence of Article VIII, Section 3, and insert in lieu thereof the word "continuous" so as to make this section consistent with privileges expressed to the Scientific Members in the Constitution.

I move the adoption of this amendment.

(The motion was seconded by Dr. Smith of Guilford. Discussion was called for There being no discussion, the motion was put to a vote and was carried.)

 $DR.\ McMILLAN:$

Amend Article VIII to provide a clarification that the Vice Councilor is an elective office, performs the duties of the Councilor in the absence, disability, or resignation of the Councilor and for succession to the Councilorship for the term to which one has been elected to Councilor office and/or Vice Councilor office.

Amend Article VIII, Section 1, by adding after the words "Councilors" words "and ten Vice Councilors." I move the adoption of this amendment.

(The motion was seconded by Dr. Reece. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN:

The Executive Council having expressed the sense that Intern-Resident Members, who, before entering practice following graduation from medical school, should pay a due equal to a Student Member, recommend amending Article IV, Section 7 of the Constitution to so reduce the due. Therefore, the Committee presents the following: Amend Article IV, Section 7. by: first inserting before the word "purpose" in line five of the said section the words "continuing educational," and second by striking from lines 14 and 16 the following words, "in an amount of ten dollars (\$10.00) per year, or such additional amount."

It being the sense of the Executive Council that this amendment be made in the Con-

stitution, I move its adoption.

(The motion was seconded by Dr. Smith of Guilford. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN: That concludes the Constitution. Now for the By-Laws.

In connection with the above amendment a complementing By-Laws revision was adopted on first reading May 7, 1958, as follows:

Chapter XII, Section 1, was amended by the addition of a sentence-paragraph to read: "The Executive Council may exempt from the payment of dues and as-

sessments any member who in its opinion should be relieved of such payment by reason of their personal circumstances." I move the adoption of this amendment to the By-Laws.

(The motion was seconded by Dr. Smith of Guilford, was put to a vote and carried.)

DR. McMILLAN:

The Chatham County Medical Society has properly considered and, by formal resolution voted, has requested that it be grouped with the component societies comprising the Sixth Councilor District instead of the Fifth Councilor District. This request has been cleared first with the Fifth District Councilor and then with the Sixth District Councilor and has the approval of each. Therefore, a revision of the By-Laws is made by striking out of Chapter VII, Section 1, the word "Chatham" among the counties listed as composing the Fifth Councilor District and by adding the word "Chatham" among the counties composing the Sixth Councilor District.

I move that this amendment be adopted. (The motion was seconded by Dr. Stros-

nider.)

(The motion was put to a vote and carried.)

DR. McMILLAN:

In order to provide a clarification that the Vice Councilor performs the duties of the Councilor in the absence, disability or resignation of the Councilor and to provide a succession to the Councilorship for the term to which one has been elected as Councilor and/or as Vice Councilor to succeed, the Committee recommends the amendment of Chapter VIII, Section 1, by the following additional sentence at the end of the section: "Upon the absence, disability, resignation or death of a Councilor the Vice Councilor shall have the duty of serving instead of the Councilor in a like manner and with all the powers and duties of the regular Councilor and for the same tenure of office of the Councilor to which time or term the Vice Councilor shall have succeeded."

I move the adoption of this amendment. (The motion was seconded by Dr. Strosnider. Discussion was called for. There being no discussion, the motion wa sput to a vote and carried.)

DR. McMILLAN:

The Committee recommends the following: Amend Chapter X, Section1, of the By-Laws by adding an "s" to the word "committee" in the first line of the section and after the word "nominations" add

the following "Grievances and Negotiations."

I move the adoption of this amendment.

(The motion was seconded by Dr. Beddingfield. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN: This one is a suggestion to the Committee related to component society requirement that its officers be elected at the regular meeting in December — and due to marked disregard now currently manifest in county elections from November to February.

Amend Chapter XV, Section 12, by striking out the word "December" in line 3 and inserting in lieu thereof the words "at a meeting on or before December 1." I move the adoption of the amendment.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN:

Amend Chapter XV, Section 5, by adding at the end of the said section a new sentence to read as follows: "No physician shall be admitted to this Society between a date following ten days after the Annual Meeting of the Society and the date of the next Annual Meeting of the Society except by special action of the Council." I move the adoption of this amendment.

(The motion was seconded by Dr. Brockmann. Discussion was called for.

(The discussion was off the record.)
(The motion was seconded, was put to a vote and carried.)

DR. McMILLAN:

Amend Chapter XII, Section 1, line 8, by adding after the words, "current year" the following words and punctuation, "; provided, that the dues of Affiliate Members and Scientific Members shall be one-half of the prevailing rate of dues for active members and; provided, further that the dues of Intern-Resident Members shall be ten dollars or a less amount to be fixed by the Executive Council for physicians continuing education in internresident training after graduation from medical school."

I move the adoption of this amendment. (The motion was seconded by Dr. Poteat. Discussion was called for. There being no discussion, the motion was put to a vote and

carried.)

DR. McMILLAN:

In view of contingencies, and the By-Laws being silent on the matter, the Committee on Constitution and By-Laws has recommended to the Executive Council that there be an expression of a time at which the President-Elect of the Society shall be installed as the President of the Society. Therefore, then, we recommend amending the By-Laws as follows: Amend Chapter X, Section 7, by adding to the end of the said section the following: "It shall be the duty of the Committee on Arrangements to establish, with the approval of the Executive Council, a time and place during one of the three General Sessions or the Banquet of the Annual Meeting at which time the President or other officers of the Society may be installed."

(There was a statement off the record.) DR. McMILLAN: I move the adoption of this amendment.

(The motion was seconded by Dr. Strosnider. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN: Mr. Speaker,

Amend Chapter X, Section 19 by adding after the word "nominations" the words "and Committee on Grievances."

I move the adoption of this amendment. (The motion was seconded by Dr. Hill. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN: Mr. Chairman. I really have not had time to get this in line. This has not been presented to the Executive Council about the Chairman-elect of the different sections. In other words, if one is made Chairman-elect of a Section he will have two years in which to formulate his program instead of the one year that he is elected. I submit this:

That the By-Laws be amended by adding to the chapter relating to the organization of scientific sections a provision for the election of a Chairman-elect of each section who shall at the next Annual Meeting become Chairman. The Chairman shall be the presiding officer and shall perform such duties as pertain to such office. Specifically amend:

Chapter XI, Section 1, on the seventh line following the word "Chairman" insert, "a Chairman-elect and Secretary for the following year shall be elected either in open session or through a committee appointed for the purpose by the Chairman of the section. The Chairman shall perform such details as pertain to such office. The Chairman-elect shall succeed to the office of Chairman at the next succeeding Annual Meeting of the Section." I move the adoption of this.

(The motion was seconded by Dr. Strosnider. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. McMILLAN: There is one more item

which Dr. Rhodes will speak to.

DR. RHODES: Thank you, Dr. Roscoe. This year we had a real problem come up in that the Committee on Scientific Work and Awards did not get some of the papers in until February, and they felt that wasn't adequate time for them to do a satisfactory survey and analysis in order to make an award. According to our present By-Laws, the titles are to be submitted within 90 days of the meeting. This Executive Council approved an addition to the regulation, that they require such papers to be submitted to the Executive Director within 60 days following the meeting if they are to be considered for making awards. That is the point.

This should read:

Section II, Chapter 11, add the sentence: "Papers read before the sections shall be submitted to the Executive Director within 60 days following the meeting if they are to be considered for scientific awards."

DR. McMILLAN: Mr. Speaker, I move

the adoption of this amendment.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Thank you, Dr. Roscoe, for your usual excellent report.

Now I think you all understand that those changes in the Constitution will lay over for a year and will be voted on again next year, whereas the changes in the By-Laws will be voted upon second reading and final passage tomorrow.

The Report of the President of the Auxiliary, let's make this official, and may I have a motion that her report in the com-

pilation be approved?

DR. SHUFORD: I so move.

(The motion was seconded, was put to a vote and carried.)

ANNUAL REPORT OF THE PRESIDENT OF THE AUXILIARY TO THE NORTH CAROLINA MEDICAL SOCIETY 1958-1959

As President to the Auxiliary to the Medical Society of the State of North Carolina, I beg leave to submit the following report:

The formalities of this office actually began before installation when a luncheon for the out-going and in-coming officers and chairmen was held at the Asheville Country Club, in Asheville. on May 5, 1958. Since

this was a departure from the past, every effort was made to provide an entertaining, yet highly informative hour for those interested in plans for the year's work.

Our parent organization was represented by Mrs. Aaron Margulis, National Chairman of Mental Health. The need for recruiting and attracting students to the Para-Medics was brilliantly pictured by Dr. Haywood Taylor, Director of Biochemistry Department, Duke University.

Having been given permission by the Executive Committee as President-Elect to reactivate the District Councilors, plans were here outlined for such a move. These past months have proven the worth of such action.

Committee Chairmen appointments were completed in May. In June, the President proudly presented "Our Best," at the Annual convention in San Francisco.

The short summer months were filled with hours of work in preparing a new type of workbook, aptly called "Information Please." Time seemed short because of the advance in date of the meeting of the Board of Directors and Workshop, held at the Forsyth Country Club, in Winston-Salem, August 26. This was an experimental change made to try to increase the attendance. Actually, it seemed to provide an earlier introduction to the year's work. Following the Board Meeting, lunch was served at which time Dr. Roscoe D. McMillan, Chairman of the Advisory Committee and Archives, brought greetings from the Medical Society on behalf of its President, Dr. Lenox D. Baker, who was unable to attend. As always, Dr. McMillan gave the members an inspiring message. Following the luncheon, a comprehensive workshop, with participants dividing into groups for study and discussion, was directed by State Chairmen of various projects. This method of instruction was received most favorably.

In late September a brief resume of the purposes and plans of the Auxiliary for the year, was given before the Executive Council of the Medical Society. It was this body that made it possible for the President and President-Elect to attend the National Conference in Chicago the following month, for which gratitude is hereby expressed.

The Auxiliary year has been crowded with activity, with a broad and worthy program.

Membership and Organization

To date, March 1, our membership is 2,103; this includes 4 honorary members, 3 life members, and 5 members at large.

Recognition goes to the newly appointed Seventh District Councilor, Mrs. Phil Barringer, for her efforts in organizing two new Auxiliaries. Anson County with 9 members and Montgomery with 5 members. Regrettably, Warren County has asked to temporarally disband. This leaves a total of 56 organizations, representing 76 counties, District 7 and 1 are 100% organized.

American Medical Education Foundation

Thirty-six Auxiliaries have contributed in the amount of \$1,351.84. The full amount cannot be correctly ascertained since many members gave jointly with their husbands. However, this is an increase over previous years to show further interest.

Auxiliary News

Informing Auxiliary members of the progress of its projects as well as its social activities has been the goal of our most imaginative Editor. Color has become an actuality in each of the four issues. "Well done," Mrs. Walter King and Hospital Saving in Chapel Hill.

Bulletin

This volume, our National guide, keeps members in the 49 states informed about serving to exchange ideas.

Civil Defense

Twenty-three counties report ACTIVE in Civil Defense, Much of this activity included training in First Aid and Mass Feeding.

Community Health

Changing the name of this project from Rural Health to Community Health has brought new interest on the level of the larger Auxiliary. This has been a year of cooperative effort on the part of every Auxiliary no matter the size of membership.

Community Service

Perhaps the greatest revelation throughout this term of office has come with the reading of each county report which tells of the thousands of hours spent in "Safeguarding Today's Health for Tomorrow." It is impossible to evaluate the far reaching effect of the helping hands extended by over 2000 doctor's wives in North Carolina as they have participated in Health, Religious, Educational, Civic, and Charitable activities.

Historian

Our most capable Historian, Mrs. Frank Jones, has not been quite so busy as last year, when she completed the History of the Auxiliary. She has kept complete records as sent her.

Legislation

An intensive drive on the part of the Legislative Chairman, Mrs. L. DeCamp, has resulted in a noticeable increase in interest throughout the membership. She reports definite activity in the Auxiliary such as letter writing campaigns, programs, and vis-

itation to the State Legislature during the General Assembly. It is felt that a closer working relationship between the Auxiliary and the Society would be extremely productive.

Mental Health

promotion of GOOD MENTAL HEALTH continues to be a major interest among the Auxiliaries. There is a growing cooperation between the Auxiliary and other community organizations in disseminating information on Mental Health especially P. T. A. and County Mental Health Associations. One Auxiliary was largely instrumental in bringing a Mental Health Clinic to her county. The outlook for improved care for the mentally ill is bright in North Carolina: in addition, many agencies are at work to prevent Mental illness before it strikes. And in the forefront of both these advances are the hardworking, dedicated members of the Auxiliary to the Medical Society.

Paramedical Careers Recruitment

With the changing of the name of this committee to include all fields of medicine, has come a greater surge of interest than ever before. Of great importance is the introduction of Hospital Career Days, as a state-wide drive for recruiting students. The need for such a program was visibly demonstrated at the N. C. Baptist Hospital and the Bowman Gray School of Medicine in Winston-Salem under the direction of the Forsyth-Stokes Auxiliary. Several other counties have this project well on the way to be carried out later in the year. "Career Days" in high schools has been popular throughout the state this year.

Over 20 scholarships totaling more than \$3000.00; loans in the amount of \$1,890.05; 4 Future Nurses Clubs, and awards to high schools student nurses in excess of \$300.00 are only a few of the accomplishments

achieved this year.

Radio, Movies, TV

A list of radio stations in the state which might be used in presenting our programs and material has been compiled by the competent chairman. This information was used to carry out the state-wide presentation of the "Health Magazine of the Air." A wide use of film has been reported covering 6 phases of Auxiliary work; "Helping Hands for Julie"—a Squibb production being widely used in recruitment.

Research

All material previously collected for State Research is being classified and catalogued so that it may be presented to the State Medical Society. Robeson County Auxiliary completed and published the book, "Our

Medical Heritage, 1775-1959." "The First Hundred Years of Medical Practice in New Hanover County" was edited by that Auxiliary, Forsyth-Stokes contributed "Physicians of Salem" and "Physicians of Forsyth 1753-1820."

Many single biographies and histories are in the process of being compiled by a large number of Auxiliaries. Permission was received from the Medical Society of North Carolina to compile a collective biography of all Past Presidents of the State Society and their terms of office. This is well on its way to completion.

Safety

This is a vital part of Safeguarding today for a healthier tomorrow. Reports from well over half of the counties indicate an active participation in this endeavor.

Sanatoria Beds

As of February 14, 1959 thirty-one Auxiliaries have contributed a total of \$698.50 to the Yoder Bed Endowment. The balance, as of that date was \$1,311.11 plus \$6,500.00 in United States Savings Bonds.

The year-round remembrance plan for our guests in the Beds has worked most satisfactorily, giving each county an opportunity to make long days brighter for the guests.

Student Loan Fund

The usefulness of the Student Loan Fund is growing as evidenced by the increased number of requests for information concerning its availability. Two new loans were made in January 1959. One loan has been repaid. There are 5 loans of \$500.00 each now in use. The balance, January 30, 195 9was \$1,-693.38. Thirty-eight Auxiliaries contributed \$471.50.

Today's Health

An intensive drive to introduce this authentic, reliable health magazine to the lay, has resulted in 649 new subscriptions being placed in public places. As of February 18, 1959, 830 subscriptions have been sold. A concentrated effort was made to place Today's Health in the doctors reception room wherever possible.

Travel has consumed much of the President's time, which is as it should be, for in no better way can close fellowship be enjoyed. The President attended 6 District meetings and 9 County meetings, several Science and Safety Fairs, Mental Health meetings and Career Days. The Auxiliary has been ably represented at many meetings which the President could not attend.

To be called upon by the Medical Society to carry out any assignment is a responsi-

bility and a privilege. The one given this Auxiliary on February 22 is no exception. The President feels keenly the enormity of this particular request. The President of the Medical Society of the State of North Carolina and the Advisory Committee have asked that each county society work directly with its Auxiliary in the matter of investigating certain textbooks which are now in use in some of the high schools of this state. A plan of action was laid before the President of the Auxiliary at the Advisory Committee meeting held in Raleigh, conducted by Dr. Roscoe D. McMillan, Chairman. Upon the passing of the motion, the President accepted, on behalf of the Medical Auxiliary, which she officially represented, the responsibility of same. At this writing work has begun. It will require the careful study and understanding of all members of the Auxiliary and Society alike. This is a joint endeavor to save our American way of life, so sacred to us all.

Dr. Lenox D. Baker, President of the State Medical Society, gave the Auxiliary a big boost last May when he appeared at the President-Elect luncheon and he has kept a watchful eye on his assisting aids all this year. As in the past, our chief advisor, Dr. Roscoe McMillan has given us much help and in return, the Auxiliary wishes to express its deep gratitude. Appreciation must surely go to Mr. James T. Barnes, Executive Director, for his constant reminders and helpful suggestions, not forgetting his unlimited patience. To Mr. William Hilliard, Public Relations Director of the Medical Society who is always ready to advise in matters of publicity, the Auxiliary expresses sincere thanks. As always, Mrs. Annette Boutwell and the Secretarial Staff has stood ready to assist, and for this spirit of cooperation, the Auxiliary is indeed appreciative.

For the President, this has been one of dedicated effort to uphold the banner under which each member marches. To follow after the leadership of 34 such brilliant Past Presidential stars, has been indeed difficult, but in no way a handicap. Reading their records, has provided the guiding light for a year of

fulfillment.

Some new tactics have been tried, new perspectives looked for and found. All of these have been made possible by loyal support, by helping hands for the President who is most grateful. It has been fun. It has been hard work. It has proven this fact: We earn our heritage by hard work, and our satisfaction may be only an inner spiritual glow.

In this our work and our dedication, we

can, with God's help, prove that the world is a better place in which to live.

s Mrs. Paul Johnson, President Auxiliary to the Medical Society of the State of North Carolina.

SPEAKER KOONCE: Now the report of Tellers on the voting on the General Practitioner of the Year: Fortune, 81; Suiter, 33: Turlington, 12. Dr. A. F. Fortune is declared elected the General Practitioner of the Year. (Applause)

SPEAKER KOONCE: We will call him

to the stand as soon as he comes.

Next is item, "Reports of Commissioners." Dr. Baker has something he wants to say.

PRESIDENT BAKER: I mentioned the Commissioners before. 1 think you people should refer to your Annual program, page 10, and you will see where six Commissions have been set up. If you will look under each one of those Commissions you will see listed the name of the Committee or the Committees that are assigned in that Commission plus the Chairman of each Committee, Now those Chairmen make up that Commission with a Chairman of the Commission. Now if you will look on over further in your program, you will see where the Committees themselves are listed. They start on page 12. If you will look over the list of names, and the number of names required there, you will have some idea of what a tremendous job your President has each year in putting men on committees. Frequently, I must say, it is almost impossible to know who is interested in that particular work of the Society, and who would best serve, and it takes long-distance calls; you don't know whether they will even serve even though they are interested. Now tomorrow I will discuss something that each of you is supposed to have had a copy of, as you registered today, called "Know Yourself." address, as President of this Society, will be pitched at that item. If this Medical Society can get those "Know Yourself" blanks filled out, we will have something that will help us in solving all problems that may come before us because we will know where members are who are alert and awart of what the situation requires.

I beg of you people representing this Society as Delegates from your various county units, in your contacts with other people at this meeting today, to ask them please to fill in that "Know Yourself" blank. If they don't want to fill it in until after Tuesday, I shall understand.

Some of the people may not know all of the implications that that questionnaire carrier, but as your outgoing President — and I think Mr. Barnes will confirm this — that information is needed, needed badly. If you will fill it in at this meeting and turn it in at the registration desk, it will be a great deal of help to your incoming President, Dr. Reece, who will meet with various former officers and other people from whom he wants advice during this meeting. In fact, he has scheduled that tomorrow morning. If some of you will get this in this afternoon it will help him tomorrow morning.

SPEAKER KOONCE: May I announce that under the present set-up individual committees will not make their reports. The Commissioner will make a report, and if he has a committee Chairman who has nothing that he wants to bring up, while the Commissioner will call on him, it will not be necessary for him to make a further presentation.

If you approve of a Commissioner's report, you are approving of all of the recommendations of the Committees which are under his Commission. Therefore we are requesting that the Commissioners come forward and bring out the recommendations which are made by the individual committees. As I say, if you approve his report, you are accepting the recommendations of those committees. We will start off with the Administration Commission, Dr. Wayne J. Benton.

DR. BENTON: Jim Barnes did not mention the seven thousand dollar surplus we had this year. This is the first time we have had a surplus in over five years. He did not point out either that the reason was that the headquarters sold \$64,000 worth of advertising in the Journal and otherwise, whereas last year they only sold \$37,000, and less than that before then.

Our net worth is now \$93,000.

This doesn't require any action of the House. It is just for information. Are there any questions?

(A report contained in the compilation for the Committee on Medical Society Headquarters facilities.

DR. BENTON: I move its adoption.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Thank you Dr.

SPEAKER KOONCE: Thank you, Dr. Benton.

The next Commission is the Advisory and Study Commission. Dr. Jacob H. Shuford,

Commissioner:

DR. SHUFORD: Mr. Speaker and Members of the House of Delegates, I call your attention to page 10 of your program, sec-

tion 2, Advisory and Study Commission, and that pretty well outlines the organization of the type of study commission of which I am Commissioner. I have been requested to read the names of the committees and the com-The Auxiliary Advisory mittee chairmen. and Archives of Medical Society History Committee, Dr. Roscoe D. McMillan. American Medical Education Foundation Committee, Dr. Harry L. Johnson. The Blue Shield Committee, myself. The Constitution and By-Laws, Dr. Roscoe D. McMillan. Credit Bureau, W. Howard Wilson; Industrial Commission, Thomas B. Dameron, Chairman: Medicare Committee, Dr. David M. Cogdell, Chairman; Student A.M.A. Chapters, Dr. Isaac Harris, Chairman; and there is an additional ad hoc committee under my commission dealing with text books in North Carolina; Dr. Bowers is Chairman of that. If you look on page 11, too, of the compilation of reports, you will find the annual report of the Commissioner of the Study and Advisory Group. This report has been presented to the Executive Council and has met with its approval.

I personally want to thank all the gentlemen who acted as Chairmen of these Committees, and the Doctors who served upon the Committees for their invaluable work, and they certainly made my job much easier. As you know, this is a new type of organization, this commission organization, and the Commissioners were just as ignorant of what they were supposed to do as a lot of people are about things they know nothing about. I wish you would, each individual would, glance over the report of Medicare Committee and the recommendations, please. The recommendation is that the Society continue to contract with the government in the

operation of Medicare.

I move that it be adopted.

(The motion was seconded by Dr. Poteat.) SPEAKER KOONCE: Is there any discussion?

DR. T. S. RAIFORD: In reading the letter to Dr. Berry (ODMC) and his response, saying that it would be impractical, I wonder if we could not use another possible approach to the Committee on Medicare, namely, the pattern used in Indiana whereby the State Medical Society pays bills submitted without any fees schedule. This has been tried for about two years and the government has come out about \$10,000 a year better. I wonder if that has been considered by the Medicare Committee or if it gives us another wedge to approach them with.

DR. SHUFORD: Dr. Dave Cogdell is sitting in the back. Did you hear that question?

DR. COGDELL: As I understand, the way Indiana works, the situation is they guarantee, the Medical Society does, that it will not go over a certain amount, and I did not feel that we were in a position to make that guarantee. The total amount of fees should not be greater than a schedule that they would approve. I don't believe our Society could back up such a program. If the fees were higher we might get caught.

SPEAKER KOONCE: As I understand the recommendation, the recommendation is that we continue to cooperate but also continue to negotiate. That is correct, isn't it,

Dr. Cogdell?

DR. COGDELL: Yes.

SPEAKER KOONCE: Is there any further discussion of this question? Are there any other questions you want to ask about this Medicare matter and our recommendation that we continue to cooperate and negotiate?

(The motion was put to a vote and car-

ried.)

DR. SHUFORD: The second among the list of committees is a Student A.M.A. Affairs Committee, Dr. Ike Harris, Chairman. His recommendation is that the student section become an integral part of the State Society meeting and that the student program be developed further.

I move that that recommendation be

adopted.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. SHUFORD: The third committee is the Industrial Commission Committee. Actually the whole report is a matter of recommendations. There are several legisaltive matters brought up, and I don't know whether any action should be taken on that

or not.

The Committee opposed two separate bills. It recommended the endorsement of the North Carolina Orthopedic Society's suggested rating guide for disabilities of upper and lower extremities along with the guide for rating facts. It recommends an alteration in the award for amputations of upper and lower extremities. It recommends that the physician, in Workmen's Compensation cases subsequently receiving liability from third parties tort-feasor action, not be knocked down by these existing schedules and they be allowed to charge usual fees to tort-feasor recoverers. The recommendation on that was from the Committee that these recommendations be accepted. I so move.

(The motion was seconded. Discussion was called for. There being no discussion, the

motion was put to a vote and carried.)

DR. SHUFORD: American Medical Education Foundation Committee, Dr. Harry Johnson, Chairman. This is simply a statistical report, and the recommendation is that there be increased participation of voluntary contributions to A.M.E.F. and that this be undertaken by the physicians of North Carolina. I so move.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. SHUFORD: The fifth is the Medical Credit Bureau Committee, Dr. Howard Wilson, Chairman. By the way, Dr. Wilson has a very nice exhibit downstairs, and I wish you would all look at it.

The recommendation is that the Committee be continued and that its work and scope

be enlarged. I so move.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. SHUFORD: The sixth committee is the Blue Shield Committee, of which I am Chairman. I wish each Member would read that entire report on the Blue Shield Committee.

I would like to call your attention to Item (b) which will answer, I believe, the Doctor's question about Hospital Care which was brought up previously.

As for Item (c), we have been requested to develop a dental rider — and I will go into that in my Blue Shield report — and

work is being done on that rider.

Item (d) is a proposed senior certificate for those over 65 years of age — those expressed income brackets are not finally correct at the moment.

I would like to call your attention to Item (f) in particular. Approximately 52% of the physicians of North Carolina participate in the Doctors' Program. There are approximately 87,000 people covered. The recommendations would be that the senior certificate be considered carefully, implemented, and acted on as quickly as possible. That will be explained later in the report of Committee on Blue Shield.

Recommendation 2 is that the Dental Rider Action be consummated and placed on sale.

Mr. Speaker, I question whether I should request that these recommendations be passed because the Blue Shield Report has not been given.

(A conversation ensued between the Speaker and Dr. Shuford.)

DR. SHUFORD: Acting in a dual capacity as Commissioner and also as Chairman

of the Blue Shield Committee, I recommend to the House of Delegates that the senior certificate be considered carefully, implemented and acted on as quickly as possible, and that the Dental Rider Action be consummated and placed on sale.

I so move.

(The motion was seconded.)

SPEAKER KOONCE: Do you understand that motion? I am not sure that I do either. Dr. Shuford, will you re-state that motion a little louder?

DR. SHUFORD: That is the reason I wanted you to look at the items on the Blue Shield Committee report. Some are of no value whatever as to action here; others are items that we hope to implement.

Now refer to page 12-7 of your compilation of reports, the report to the House of Delegates, Medical Society of North Carolina, May 1959 from the Blue Shield Committee,

J. H. Shuford, Chairman.

I would like to call your attention to Section 1, "The Integration of Hospital Care Association of Durham, North Carolina, into the Blue Shield Doctors Program, and the Recognition of Hospital Care as a Blue Shield Agency allowed to sell said program. The second, the stimulation of participation and interest in the Doctors Program among the members of the North Carolina State Medical Society.

These were considered to be the Committee's two main objectives for the year.

I call your attention to the next paragraph:

"Due to the failure of Hospital Care Association to fulfill and carry out the requirements and regulations as set forth by the House of Delegates in session at Asheville, North Carolina, on May 5, 1958, the Executive Council meeting in Raleigh. North Carolina, on September 21, 1958, directed the Blue Shield Committee to proceed no further with integration of Hospital Care into the Blue Shield Program until such time as the Council directed otherwise."

I call your attention then to page 3, the last paragraph on that page, "Due to the socialistic threat of the Forand Bill, the A.M.A. has requested (1958) all State Medical societies to vigorously encourage voluntary health insurance for persons over 65 and provide services at reduced fees for older persons of reduced income."

After discussion of all the ramifications the Committee deferred any specific recommendations to the House of Delegates for service benefits at reduced fees and income limits for persons 65, and over, until further consideration could be given at future meetings.

I wish to offer at this time as an addendum to this Blue Shield Committee report, the Blue Shield Committee met on May 1, 1959, and two items were on the agenda. We met again with the dentists and an insurance committee representative. There was quite a discussion of nomenclature, procedures and fees. Agreement was reached on all controversial items, and it is recommended that a proposed rider be approved by the Executive Council and the House of Delegates, and I so move.

SPEAKER KOONCE: He is asking that his recommendation that the dental rider be approved, be passed at this time. Is there a second to this motion? Is there any discussion or any question as to whether we should approve of Hospital Saving putting in a dental rider? If there are no questions I will put it to a vote.

(The motion was put to a vote and car-

ried.) DR. SHUFORD: Item 2 on this addendum report: after long discussion, the following recommendation regarding the senior certificate was approved by a 5 to 1 vote, the opposing vote by proxy. Recommendation: That the senior certificate as outlined in the Annual Report of the Blue Shield Committee be adopted. It is also recommended that predetermination of eligibility based on uniform limits be mandatory, and that participation by physicians be voluntary, and the Committee expressed the hope that the senior certificate could be included in the Doctors Program and that participation by physicians would include aspects of the Doctors Program.

I want to explain that last sentence. We felt that if the doctor agreed to participate in the Doctors' Program as it now exists, he would also agree to participate in the senior certificate, and if that is the wish of the Medical Society and the House of Delegates, it would be an integral part of the Doctors' Program, and administration would be much easier.

I call your attention to the Annual Report of the Blue Shield Committee which you will find on page 4, the senior certificate. This is 12-7. This is an example of the proposed senior certificate, and this concerns only the blue Shield aspects. This has nothing to do with hospital costs. Doctors are concerned only with the Blue Shield aspect, and I think we can understand the recommendation of A.M.A. on reduced schedules for 65-year-old people of low income. We felt, and the Committee felt, that inserting schedule D as it now exists in the Hospital Saving Program, which is the \$200 schedule,

if we could pay a 75% schedule, we would be complying with the wishes of A.M.A., and we are bringing out a reduced fee schedule, and this would approximately compare with the old Hospital Saving C schedule which was the \$150 schedule, the medical endorsement.

The medical endorsement for non-operative in-patient admission is five dollars for the first day, three dollars for the second through the nineteenth day, two dollars for the twentieth through the thirtieth day — these are amounts suggested by National Blue Shield and could be extended to 120 days, if necessary, for a small additional rate.

Cancer therapy and diagnostic X-Rays

are self-explanatory.

As for income limits, the suggestion here is \$1500 for an individual, \$2400 for a man and wife (approximate maximum Social Security retirement benefit payments).

If you will read a bit further down, you will get an explanation. It says, "As a special Blue Shield program sponsored by the Medical Society of the State of North Carolina to aid and encourage voluntary health insurance for persons 65 years of age and over participating physicians agree to accept scheduled allowances as full payment for persons who hold 'Senior Certificate' coverage who have no additional coverage for professional services and are within the income limits."

The estimated cost for surgery and anaesthesia is 90 cents per person per month, for medical rider 60 cents, for radiation rider 50 cents, or a total of \$2.00, medical bene-

I shall be glad to answer any questions if

I can make it any more clear.

SPEAKER KOONCE: Do you make a recommendation at this time?

DR. SHUFORD: I recommend that the Senior Certificate as proposed be accepted, and I move its adoption.

(The motion was seconded by Dr. Millard M. Hill.)

 $SPEAKER\ KOONCE$: The floor is open for discussion.

DR. RAIFORD (Buncombe): Mr. Speaker, I think it is rather unfortunate that we have not had time to discuss this at the local level so that every one of our County medical members understands it.

It was brought up in Buncombe County about three weeks ago, and the feeling of the majority was that it should not be approved. I think the reason for that was because they did not understand it.

After going into it a little more myself I understand it, and I am 100% for it, but I

am still bound by the wishes of our local Society to vote against it.

This is an attempt to stave off the Forand Bill, and in essence the amount received is essentially what they would get under the Forand Bill. Under the Forand Bill the taxpayers pay the premiums. Under this proposed rider or addition of the Senior Certificate, the insured pays the premium. I think if all the members understood that they would be very much for it. However, they do not understand it as yet, and I am afraid, as I just said, we are bound by the wishes of our County Medical Society to vote against it. Is there any way this could be delayed, or would it hurt the cause or fail to stop the Forand Bill if it were delayed for a while?

SPEAKER KOONCE: I am going to let Dr. Baker speak on that.

PRESIDENT BAKER: Earlier in the morning we mentioned a trip Jim Barnes and I made to Washington, and when we discussed the Forand Bill with as fine a group of men as I think any State has to represent them, those men that we have from this State in Congress, they tell us that we have to have an answer. following that trip, I went on to Chicago to the A.M.A. offices, and they were fighting the Forand Bill in any form whatever that would bring medicine into the Forand Bill in one vein and one vein only—foot in the door. Now the big difference between this and the patient paying for the bill through his own policy and putting it through the Forand Bill with the government paying the policies, is that there is no foot in the door with this; it will stop it.

Some one asked if there is any danger in delaying. In January and February the feeling was that we were fairly safe from the Forand Bill; that it had been moved into a committee, and a rather powerful committee, where we had good holdings on it. Now, if you will follow your trends you will notice that the Speaker of the House in Congress —has apparently made some trade with some people about something getting to the floor of Congress. There is no way in the world of defeating the Forand Bill if it ever gets to the floor. There are too many 65 year old people who would go for the man who voted for it, and there are also many people of a certain element in this life who do not care to look after the previous generation that would be glad to see the Forand Bill go through to unload them as part of their charges. I don't think, Ted, that this thing should be delayed. I understand your position in it, but if medicine is going to give an

answer, I have an idea that this thing should be voted on favorably here today, and the first thing we want to do is really pour this to the press, as this was the Medical Society's answer. And not only that, but tactfully explained letters should go to every man in Congress from this State, including the Senate. If we postpone we will always be there too late with too little. I think we better hit 'em and run, and remember that old man Forrest and his fighting in Tennessee and hit 'em and run again. They are weak here and this is a good place to strike, and I can't speak too strongly in favor of this recommendation.

SPEAKER KOONCE: Dr. Raiford, in answer to your question on procedures: The only way that that could possibly be done and to have it passed within any time within reason where it would be of any value, would be to postpone it until tomorrow, and that would be of no value to you, as I understand it.

Much discussion ensued reasoning whether action was timely.

SPEAKED KOONCE: Dr. Reece, as you all know, is our President-elect. Dr. John Reece is recognized.

DR. REECE: Blind opposition to many of these schemes that are before Congress right now is going to lead us to nothing but chaos. This is a positive program. We have developed an insurance scheme that is logical. We must remember that it has many deficiencies. Of course, it isn't perfect, but it is a scheme that we can direct ourselves. Our own committee, the Blue Shield Committee of the State Society, will work with Hospital Saving and with that we can develop a Blue Shield Program. I certainly urge positive action on this program and support. Let our representatives in Congress know that we have done something in a positive way to help to take care of many of the unfortunate individuals among the senior citizens as they are faced with illness and catastrophic circumstances because of ill-

DR. WILKINSON (Wake): Mr. Chairman, I am a member of the Board of Directors of Hospital Care, and I think this Board and the House of Delegates should know that we have under consideration now the issuing of a policy for our elderly people over 65 to follow along with your Blue Shield Plan. Your Board of Directors I am sure wish to see this passed now before this House so we can take similar action with your Hospital Care Board.

SPEAKER KOONCE: Dr. Wilkinson is

President of the North Carolina Academy

of General Practice.

DR. SAMS: Mr. Speaker, I call the attention of the House of Delegates to this fact, that in Washington we have twelve Representatives. They have demanded from us something that will let them have an argument to put up against the Forand Bill. The Forand Bill is simply a stepping stone as you know if you have studied it. It is a great, long step toward socialized medicine, but let me say this, that the Council has studied this thing thoroughly and went to it hour after hour of discussion and then voted to uphold it unanimously with all the officials of the State Society present.

We plead with you now not to shut the

door to this thing. Let's vote for it.

(Applause)

SPEAKER KOONCE: Any further dis-

DR. PATRICK (Lenoir): Mr. Chairman, as I understand it, we are discussing this as a Blue Shield proposal.

SPEAKER ROONCE: That is right. DR. PATRICK: I would like to know if

the Hospital Saving has a Blue Cross Plan

to go along with this.

DR. SHUFORD: This is a Blue Shield Committee, but I will be delighted to tell you what I know about it. They have told me that if this action is not passed, if doctors want no part of it, they will present a strictly hospital program to people 65 years of age in North Carolina. However, I can tell you that they anticipate that the hospitalization portion of the program for the aged will cost approximately \$4.00 per month per person as set out in their proposed policy. They have been nice enough to wait until we took action. Actually, they have been ready to present such a program, but they were nice enough to give us a chance to have our say on the Blue Shield portion.

SPEAKER KOONCE: We have had a rather full discussion of this, but Dr. Rousseau wants to say something and then Dr. John Rhodes, and if anybody else has anything to say lets say it rather briefly because

of time.

DR. ROUSSEAU: Thank you, Mr. Speaker. Having represented the A.M.A. as a key legislative member — and there are members from every district on there believe that this program is a positive program, and unless we accept it we are surely headed for complete socialization. The Hospital Association and the American Nurses Home Association and the A.M.A. have jointly worked on this program. Unless you do something about it pretty quickly you can be sure that the Forand Bill or a Bill similar to it, each one worse than the one before, will go through.

SPEAKER KOONCE: The question has been called for. I think because of the importance of this I am going to ask you to rise and give your vote. All those in favor let it be known by rising. Thank you, gentlemen. Those opposed will now rise. I think it is pretty obvious that the motion has been carried, by a preponderant vote.

The Chair, for information, would like to reaffirm that the Blue Shield Report included the stand that the Hospital Care Association had taken in not changing their Board structure according to the request of the House of Delegates of last year. That has been acknowledged by the Executive Committee and things remain more or less in status quo. I am giving this as information. If there is any action to be taken it can be taken from the Floor because I understand the Blue Shield Committee has no recommendation. It is just information. If there is nothing further on this, we will ask Dr. Shuford to go ahead with his report of his Commission.

DR. SHUFORD: Gentlemen, I am sorry that we have been so long, and I hope that

I am not too responsible for it.

We have only one thing left on the Commission's report, and this has been the ad hoc committee with Dr. Bowers as Chairman. This committee was appointed to consider the question of the propriety of some of the textbooks that are being used in the schools of North Carolina. I will not read the whole report. I will just call to your attention a few comments of the committee and their recommendation.

"The Ad Hoc Committee of the Medical Society of the State of North Carolina has reason to believe that certain textbooks used in our public schools contain radical and objectionable doctrines foreign to the American

way of thinking."

They have special reference to a sociology text that is used in the public schools.

"Item 1. It presents a propaganda line undermining respect for the Constitution of the United States" — by the way, I am merely quoting the committee's report. I have no personal knowledge.

"Item 2. Students are led to assume that they have a right to be supported by the government, and that socialism is our only so-

lution to our economic problems.'

"Item 3. It insinuates that our people are not getting a square deal and creates the impression that reform is possible only by establishing a new social order.

"Item 4. It advocates socialized medicine as the answer to the people for satisfactory medical care."

The committee checked with the Textbook Commission of North Carolina, and the feeling was, as this committee indicated, that it is impossible for the Commission to read textbooks because of the tremendous volume of reading material, and the conclusion of the committee was that the books are a pipeline from author to teacher with no in-between evaluation of the program.

They go on to quote the Sons of the American Revolution, the Ladies Auxiliary Committee which has worked on this; they quote the Daughters of the American Revolution, the American Legion, the Veterans of Foreign Wars. They say that these organizations have been making a similar investigation of this so-called textbook situation.

This is their recommendation:

"The Ad Hoc Committee recommends that pressure be brought to bear locally and at the State level to effect the substitution of a good course in American History for the present course in sociology in the high schools of North Carolina."

I move that the recommendation be adopted.

(The motion was seconded. Discussion was called for.)

DELEGATE: It seems to me that this is a matter that should be the concern of all citizens, not just the members of the Medical Society. I should hate very much to see the Medical Society get into something that is the province of the entire citizenship. Seconly, it is not related to the primary purposes of the organization as set forth in our Constitution and By-Laws.

I should like to offer a substitute, that this information, if it is felt to be detrimental, be made available in a suitable way to the membership of the Society so that they may take part in a more intelligent way with other citizens on the local level, but not on the basis of acting through the A.M.A.

DR. PEELE (Lenoir): I don't believe Dr. Bowers is here. We are making one plea, and that is that you read the textbooks used in your high schools and grammar schools, such as those of Sociology, American History, World History and Economics. I think you will be amazed and appalled. We are working through the Médical Auxiliary, and each County Medical Society has been provided with ample background material on this subject. It is anticipated that the Auxiliary will present this material to the County Society. Please read these textbooks. This is a serious problem, and we beg you to go into

it with care and consideration.

SPEAKER KOONCE: Thank you, Dr. Peele. Dr. Peele has done all the work on this. The recommendation is that they go on with the work they are doing. There have been calls for the question.

(The motion was put to a vote and car-

ried.)

Dr. Shuford has one correction to make.

DR. SHUFORD: Mr. Anderson, our attorney, in the Industrial Commission report, item (f), indicated that the House of Delegates approved the recommendations. However, item (f) is interpreted that we do not demand legislation at this session of the General Assembly and that it be referred to the Legislative Committee for action.

SPEAKER KOONCE: I don't think that change warrants or necessitates any action now

I am now going to ask Dr. Baker if he will read the report of the Nominating Committee and then we will have a vote on the election of officers for the next year.

PRESIDENT BAKER: This is a nice occasion, that this announcement can be made at the first official meeting of this body. In th past most of us have gone home without knowing who our officers were. We did not have the pleasure of walking about for the next two days and slapping them on the back.

Your Nominating Committee, on the report from the Chairman, Dr. Graham Barefoot, makes the following nominations:

First, the Convention site for the 1960 meeting will be Raleigh, North Carolina. (Applause)

Member of the North Carolina State Board of Health for a three-year term, Dr. Earl W. Brian, of Raleigh, term expiring in 1961. (He is serving out a previous term.)

Dr. Roger W. Morrison, Asheville, succeeds himself for the three-year term for the State Board of Health.

For Vice Councilor of the Fourth Medical District, Dr. Donnie Hue Jones, Jr., of Princeton.

For Councilor of the Fourth Medical District, Dr. Edgar Theodore Bettingfield, Jr., of Stantonsburg.

For Vice Councilor of the Second Medical District, Dr. Ernest W. Larkin, Jr., of Washington.

Councilor of the Second Medical District, Dr. Lynwood Earl Williams, of Kinston.

Vice Speaker of the House of Delegates, Dr. Edward W. Schoenheit, Asheville, and our immediate past President.

Speaker of the House of Delegates, Dr. Donald B. Koonce, Wilmington.

Second Vice President, Dr. William Walton Kitchin, of Clinton.

First Vice President, Dr. Charles Millner

Norfleet, Jr., of Winston-Salem.

Nomination for the President-Elect was unanimous. It is our dear friend, Dr. Amos Neill Johnson, or Garland, North Carolina. (Applause)

SPEAKER KOONCE: Do I hear nomina-

tions from the floor?

PRESIDENT BAKER: Do I hear a motion that the Secretary cast the unanimous vote?

DR. STROSNIDER: I move that the report be accepted and that the nominees be declared elected by unanimous vote.

(The motion was seconded and carried

unanimously.)

SPEAKER KOONCE: Now, do I hear a motion that we recess until two-thirty?

(Upon motion regularly made and seconded, it was voted to recess until two-thirty o'clock.)

HOUSE OF DELEGATES MONDAY AFTERNOON SESSION May 4, 1959

A continuation of the first session of the House of Delegates convened in the Auditorium, Dr. Koonce, the Speaker, presiding. The time was two-thirty o'clock.

SPEAKER KOONCE: Dr. Raney, will you come up, please, and add to the report of the Annual Convention Commission.

DR. RANEY: Mr. Speaker, this Annual Convention Commission consists of six committees that have arranged the facilities for the annual session of which Dr. John Rhodes is Chairman; the Committee on Credentials of the Delegates to the House of Delegates, of which Dr. Milton Clark is Chairman; the Committee on Audio-Visual Post-Graduate Instruction, of which Dr. Leonard Goldner is Chairman; the Committee on Scintific Exhibits, of which Dr. Everett Bugg is Chairman; the Committee on Awards and Scientific Works, of which Dr. Rowland Bellows is Chairman; the Committee on the Medical Golf Tournament, of which Dr. Walter Watts is Chairman.

The report of this Commission has been published in the compilation. I have nothing to add to it at this time. I shall be glad to

entertain any questions.

This Commission really should run itself because its Chairmen are so conscientious

and have been so efficient.

SPEAKER KOONCE: If there are no recommendations to make and nothing to be voted on, we will pass on unless there are questions to be asked.

The next Commission report is Profes-

sional Services Commission, Dr. George W. Paschal.

DR. PASCHAL: Mr. Speaker, Members of the House of Delegates: My Commission, as you know, comprises six committees as listed in the program. Before remarking about these, I would like to thank each and every member of each committee for their help and cooperation in the carrying out of my particular function. I would like also to pay particular tribute and also particular thanks to our excellent Secretary, Mr. James Barnes. He is a busy man. He attends all of them that he can get to, and without his help we would be at a loss to carry on.

The first of these committees is the Committee on Emergency Medical Service and Military Affairs, of which I am Chairman. This Committee makes several recommendations pertaining to our Emergency Medical Service program in North Carolina that works in conjunction with our State Civil Defense office. The Committee recommends:

1. That each county hasten to formulate

a plan.

2. That it conform in general with the plan written at the State level and with the plans and procedures of the State Office of Civil Defense.

3. To determine the number of county medical societies that have a plan and get an actual copy of these plans in the hands of the Medical Director under the State plan. (Under this provision these plans would be sent to me at Raleigh at our Executive Offices.)

4. Secure documentation of the disaster plans and a roster of personnel which have been developed by the general medical-surgical hospitals in the State who conform to the standards of the Joint Council on Hos-

pital Accreditation.

5. That the Counties adopt the disaster plans developed by the general medical-surgical hospitals in the community and place these on an operational basis and integrate these plans with the Office of Civil Defense plans at the County Society level.

6. To bring up to date the roster of the personnel participating in these disaster plans as developed by the general medical-surgical hospitals.

Unless these are kept up to date, of course, in time of emergency we would be at a loss to implement a plan of emergency medical service.

The Committee approved and has on display here a 200-bed hospital unit which I hope all of you here will take the opportunity of seeing. We urge that all County Societies

complete their plans for emergency medical service as quickly as possible.

Mr. Speaker, I move the adoption of these

recommendations.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. PASCHAL: Next is the Committee on Eye Care and Eye Bank, the Chairman of which is Dr. H. M. Dalton of Kinston. Their report is in the compilation, and I have nothing to add to that. I move its adop-

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. PASCHAL: The third is the Committee on Insurance, of which Dr. Joseph W. Hooper of Wilmington is the Chairman, and I am happy to report to you that this Committee, following the conference with the representatives of the underwriters of our State Insurance Program, have taken a ten per cent reduction in the premium during the past year. The experience of the underwriters is to be again reviewed in October, and at that time we hope that the experience will be favorable enough to possibly institute another reduction.

I will not read all of this report, but I would like to point out one of the sound and chief recommendations of the Committee. The Committee recommends that the medical societies should take an active part in acquainting the general public as to what should be expected from health insurance. We think that this is important. I move the

adoption of this recommendation.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. PASCHAL: The next is the Committee on Necrology, of which Dr. Charles H. Pugh of Gastonia is Chairman. It is in your

compilation.

Next is the Committee on Nursing, of which Dr. Harry L. Brockmann of High Point is Chairman. He and his Committee have given much time, much effort and much of their skill to carrying out the functions of this Committee. I would urge each of you to read the report as it is recorded in the compilation, but I would like to take this opportunity to inform you very briefly of some of the things that we are doing.

The American Hospital Association appealed to the National League for Nursing to convert its Board of Accreditation of Nursing Schools into a joint Board with representatives from the A.M.A., American Hospital Association, American Nurses Association, and National League for Nursing. Up to the present the National League for Nursing considers accreditation the function

of nurses only.

Recently there has been an increase in the percentage of failures on nurses State Board examinations for licensure in the United States. We in North Carolina sent a resolution to the Trustees of the American Medical Association asking for medical representation on the Blue Print Committee which selects the questions for the State Board of examinations.

This letter was sent. Dr. Brockmann has since had some communication concerning this, and he is fortunate in having on the Committee of the American Medical Association one of our own representatives, Dr. Elias Faison, who is on this Committee to consider this problem.

SPEAKER KOONCE: Does this Com-

mittee have any recommendations?

DR. PASCHAL: Nothing except that the report be approved.

SPEAKER KOONCE: If Dr. Brockmann is here, we would like to have him say a few words if he will.

DR. BROCKMANN: We all have a great deal to do so far as nursing is concerned with our patients, but we have very little to say about the conduct of nursing education. As a result, we have drawn up this resolution which is to be considered by the Trustees of the American Medical Association, by the House of Delegates. I think reading the resolution will explain it pretty well, and I will proceed to do that. It is not long.

(The resolution was then read, beginning "Whereas the American Medical Association House of Delegates in Minneapolis in 1958" down to "... in nursing education and service in general, etc.... needed in this nation." This resolution appears in full in the Council meeting.)

That resolution, as Dr. Paschal said, has already been put in the hands of the A.M.A. Committee of Education and is up for consideration. We have learned from them that since it was approved only by the Council of the State Medical Society, in which it was very definitely approved, they would rather have the approval of the House of Delegates. I hope there will be no objection in the House of Delegates, but for psychological reasons we would like to have a hearty approval of this by all of you men. I move the adoption and approval of this resolution with instructions that it be sent to the American Medical Association House of Delegates.

(The motion was seconded by Dr. Stro-

snider. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Dr. Paschal will

continue.

DR. PASCHAL: Thank you very much,

Dr. Brockmann.

The sixth and final Committee is the Committee on Post-Graduate Medical Study and you will find this in your compilation, and I have nothing further to add to that. I move its adoption and the adoption of this Commission report.

SPEAKER KOONCE: Thank you, Dr.

Paschal.

I now call for a vote to approve the Commission's report with the recommendations which we have already approved.

DR. SHUFORD: I move that the Com-

missioner's report be accepted.

(The motion was seconded, was put to a

vote and carried.)

SPEAKER KOONCE: Next it is a very pleasant duty on my part to recognize a very lovely lady whom we are all very fond of; so I wonder if Mrs. Paul Johnson, President of the Medical Auxiliary, will come and say a few words to us.

(The House arose and applauded.)

MRS. PAUL JOHNSON: Mr. Speaker, Mr. President and Members of the House of Delegates: Once when General Carlos Romulo was asked what sort of speech he was going to make to the United Nations, he said, "I have two kinds of speeches. One is my Mother Hubbard speech which covers everything and says nothing. The other is my French lady's speech which covers the essential points."

I have no speech to make, just greetings from the Medical Auxiliary. We appreciate the privilege of being able to be your public

relations agents so to speak.

We understand that you have enjoyed yourselves reading our annual report. I am sure you have read every word of it, having nothing else to do. I hope you approve. We have tried awfully hard to represent you in the way you would like. We welcome your criticism. We appreciate your cooperation. We depend on you as the unsung heroes who allow us to leave our own fireside to go about the necessary duties of the Auxiliary.

We want to thank especially Dr. Roscoe McMillan who is Chairman of the Advisory Committee and Mr. James Barnes who has been our constant reminder of things which we have left undone and things which we are supposed to do.

Thank you so much for allowing us to be

vour aide

(The audience arose and applauded.)

SPEAKER KOONCE: Thank you, Mrs. Johnson. That is one of the higher moments of this meeting.

I dont' mean to be rushing through this. We will hear next from Dr. Beddingfield on

the Public Relations Commission.

DR. BEDDINGFIELD: Mr. Speaker and members of the House of Delegates: The report of the Public Relations Commission was mimeographed and handed to you this morning. There are a few additional items besides those you will find in the compilation and my comment on them.

First of all, I would like to say "amen" to the remarks of the preceding Commissioners, thanking our State officers, our President, our Executive Director, for the help that they have given to the committees and

to the commissions.

In addition to thanking Mr. Barnes in this public relations report, I would like to pay particular tribute to Mr. Bill Hilliard. We sort of take Bill for granted a lot of times. He is a professional man. He is being sought after for other groups to do the same thing he is doing for us, and I think we are lucky to have him.

In your compilation, the first committee is the Committee on Hospital and Professional Relations and Liaison to the North Carolina Hospital Association, Dr. Theodore Mees Chairman. This Committee really has had several difficult situations handed to it this year in the form of disputes between the administrators of hospitals and the professional staff of hospitals. They have done a wonderful job with a difficult task and ironed out a bad situation. I think the only thing that might require your consideration is this:

One of the duties-the title of this committee is Liaison to the North Carolina Hospital Association-and this year in spite of the fact that a meeting was set up well in advance and was acknowledged by members of both organizations, when the time came to hold the meeting the medical representatives were there and no representatives of the North Carolina Hospital Association showed up. So it would appear that there is very little in the way of liaison that was carried out for we were completely ignored. As Commissioner I recommend that for the 1959-60 Society year another meeting with the North Carolina Hospital Association be scheduled with a reminder letter going to the President of the Medical Society and to the President of the hospital group.

I submit that as a recommendation and move its adoption.

(The motion was seconded. Discussion was

called for. There being no discussion, the motion was put to a vote and carried.)

The second committee is the Committee on Legislation. I am sorry Dr. Poteat had to go out because he is the one that has done the work.

The Committee on Legislation has been very busy during this session of the General Assembly. I think they have been successful in their efforts. The most notable achievement in my opinion has been the passage of the Polio Vaccination Bill which, as you all know, has amounted to a record.

In addition to the effort spent on that Bill, we also supported the bill regarding the chemical test for alcohol in cases of suspected drunken driving and lent our aid in other safety measures sponsored by the Department of Motor Vehicles. The success of these measures has been somewhat less than notable.

There have been many, many other bills that have been reviewed not only by our Chairman of the Legislative Committee but also by Mr. Anderson and by Mr. Barnes, and, so far as we know, nothing has been done. We have been staying pretty well out of controversial things that neither hurt nor helped. This Committee has spent many, many hours, and written many letters, and made many telephone calls. We hope unless something surprising happens in the closing hours of the Legislature they will not have any more urgent work to do at this session.

There are no recommendations. This is presented for information.

The third committee is the Committee on Medical-Legal Matters, Dr. Bennett B. Poole, Chairman. The activities of that Committee are set forth in the compilation, and the only comment I have to make is this: Since we in this State adopted the two professional codes between the legal and medical professions there has been adopted a national inter-professional code between the medical and legal professions. Our Medico-Legal Committee composed of the representatives from the Bar Association and representatives from our Association are making technical changes in our inter-professional code to bring it into conformity with the national professional code. None of these changes are of great moment and are for the most part purely technical changes.

In order to expedite the handling of these changes and bring our code into line I am going to make the recommendation that the Medico-Legal Committee be empowered to make these technical changes and make it a legal part of our inter-professional code. That will save a year's time and keep it

from having to come up next year. If you want to accept that on faith, you may. If not, you can just wait until next year. We have people here who are prepared to discuss these technical changes if you would like to hear them.

I move that our Committee be empowered to make technical changes to bring our code into conformity with the legal code.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. BEDDINGFIELD: The fourth Committee is the Committee on Public Relations of which I am Chairman. Our work is pretty well summarized in the committee report which you will find in the compilation.

The only comment I would make about our work is that the Conference of County Society Officers which was held at Pinehurst in January was very well received and it is hoped that such a meeting will be held next January with some refinements. We have been pleased to note that the American Medical Association has adopted some of the material we have used at this meeting and are now setting up the material and putting it out in the form of a kit as a suggestion to all State Societies or orientation meetings for newly elected County Presidents and other Society officers. We think this is a very fine recognition of our Committee's work.

The fifth Committee is the Committee on Rural Health and General Practitioner Award, Dr. Hugh A. Matthews, Chairman. This has continued to be one of our more active committees. Their work is summarized in the Committee report. I don't think there is anything that requires any action. They are planning in the next year to make some departure from the State Rural Health Conference or Workshop idea, and I understand they are thinking in terms of, instead of having medical district meetings in alternating districts on alternating years, having four regional meetings in the Northeast, Northwest, Southeast, Southwest parts of the State. I don't think that requires any action by us. It is also an approved project of standing.

The next committee is an *ad hoc* committee, known as the Committee on Liaison to the Insurance Industry, Dr. Frank W. Jones, Chairman. Since this is a new committee and its creation and purpose might be of interest to some members of the House of Delegates I will read what appears under the name of that Committee.

"At the direction of the President and the Executive Council of the State Medical Society, the Commissioner was authorized to

form such a Committee to function as an ad hoc committee during the 1958-1959 Society year. This organization was carried out and an initial meeting was held in Greensboro with representatives of the Health Insurance Council and its North Carolina component committee in January 1959. At this initial meeting organization was set up with co-chairmen elected from the medical and from the insurance groups, an agenda of items of mutual interest was prepared, and many of these were explored, and a decision was made regarding further meetings. A second meeting of the Committee was held in Raleigh in April. Examples of the areas of mutual concern which need to be discussed by such a group are as follows:

1. Utilization of standard insurance claim forms.

2. Promotion of the sale of voluntary health insurance as a continuing fight against the threat of social legislation.

3. Availability of health and accident insurance to older citizens, school insurance,

fee schedules, etc.

"Inasmuch as the work of this Committee up until this point has largely been exploratory, no formal Committee report is being made for this year."

"The recommendations of the Committee

are:

"(a) That the ad hoc Committee has now gained enough experience in its appointed duties to be able to make recommendations to the governing body of the Medical Society of the State of North Carolina, and inasmuch as the Committee by unanimous vote has requested that they be removed from the ad hoc status and be made a standing committee within the framework of the Society, it is my recommendation as Commissioner that this Committee be made a standing committee, and in my opinion it should be placed under the Advisory and Study Commission along with the Committee on Blue Shield and the Committee to Work with the Industrial Commission of North Carolina. This recommendation is made inasmuch as there seemed to be areas of mutual interest between these committees that deal with various phases of health insurance."

Before we go into this recommendation, I want to make a further comment. These people in the commercial insurance industry I believe are really our friends. As Dr. Baker brought out in the Council meeting yesterday, we are working with the Forand Bill and socialized medicine because it would change our way of practicing medicine. It would put these boys out of business com-

pletely, and we certainly should welcome their support. I am afraid maybe we have ignored their support in deference to the

Blue plans for a long, long time.

The Health Insurance Council is an organization of these commercial insurance companies. They want to police themselves, they want to raise their own standards, they want to know what type of policies we wish made available to our patients. They are willing to listen. They have an exhibit with a representative from their New York office in the back part of the basement downstairs, and I invite you to stop by their exhibit.

I move that the report regarding this Liaison Committee to the Insurance Industry

be adopted.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Now may we hear a motion to adopt the Commissioner's report including the recommendations?

DR. RAIFORD: I so move. (The motion was seconded.)

 $SPEAKER\ KOONCE:$ Are there any questions?

(There being no questions the motion was put to a vote and carried.)

SPEAKER KOONCE: I promised you that we would have the caucus meeting for nomination of the Nominating Committee at three o'clock. I would like very much for you to get to your section station for caucus of the different districts for organization of the Nominating Committee with the understanding that a member of the Nominating Committee may be re-elected for one year only. They are elected every year. They may be re-elected for one year and then not re-elected until they have had an absence of a year. As I understand it, the only doctors on the present Nominating Committee who are eligible for re-election are Dr. Peele and Dr. Poteat. If you will go to your district caucuses, I am going to ask you to get back in twenty minutes. Bring in as soon as possible your nominations for the Nominating Committee.

(There was a recess for caucusing.)

SPEAKER KOONCE: All right, gentlemen, if you will come to order again.

Election of the Nominating Committee from the different districts are as follows:

First District, Dr. Zack D. Owens; Second District, Dr. James C. Peele; Third District, Dr. Robert Fales;

Fourth District, Dr. Hubert Poteat, Chairman:

Fifth District, Dr. D. E. Ward, Vice Chairman;

Sixth District, Dr. Paul Maness; Seventh District, Dr. Jesse Caldwell; Eighth District, Dr. George Holmes; Ninth District, Dr. Jake Shuford; Tenth District, Dr. James S. Raper.

As I understand it, these men are automatically elected and we don't need any election of the House of Delegates, they hav-

ing been elected by their districts.

The newly elected Committee on Nominations will promptly assemble in the Tropical Room of the George Vanderbilt Hotel to receive instructions on their responsibility and complete their organization. Those men will meet with Dr. John Rhodes, Secretary.

DR. RHODES: I would like to appoint Dr. J. C. Peele of Kinston as temporary Chairman and suggest that the Committee retire as soon as possible to the Tropical Room on

the mezzanine floor.

SPEAKER KOONCE: I am going to request the new Committee on Nominations to hold their meeting up for ten or fifteen minutes. Dr. Caldwell is next on the program to introduce two speakers. If they will hold it up for about fifteen or twenty minutes and then have the meeting it will be appreciated.

I am taking the prerogative of changing the schedule just a little bit. These are two very important people, and I would like to call on Jesse Caldwell to introduce the sub-

ject.

DR.CALDWELL:Thank you, Speaker. President, Ladies and Gentlemen: The matter for consideration by the House of Delegates concerns the proposed plans to implement the provisions of the Self-employed Individual Retirement Act of 1959 if this legislation is enacted by the 86th Con-

This legislation has been known, as you know, as the Keogh-Simpson Bill or HR-10. All of you are generally familiar with the provision of this Bill, and I am sure you understand the tremendous potential advantages it will allow for the self-employed.

President Baker considers the matter to be of sufficient importance to the Society members that he has arranged to have the subject presented and developed as a special item on the agenda of the House of Delegates. President Baker has also appointed a special committee to keep abreast of the legislation and consider methods of implementing its provisions for additional benefits to the members of this Society.

As the Keogh Bill now stands, it provides for both insurance annuity programs and trust fund programs to be used for retirement purposes. We are especially privileged to have with us by invitation of the President two speakers to explain more fully the possibilities of the Keogh Bill for our information and guidance. President Baker

will introduce our first speaker.

PRESIDENT BAKER: Introducing this speaker is of special significance to me. My first contact with Duke University was in Atlanta, Georgia, in 1929 at the Old Southern Conference Basketball Tournament when Kentucky's great team was ranged against North Carolina's. Duke infused great new interest into the Conference when it sent a great basketball team down there, and one of the players was Bill Werber. I volunteerd my services to Duke—they didn't have a trainer—and as a result of that contact I later became trainer at Duke the following fall. Bill was one of the first athletes whom I ever worked with at Duke University.

I think many of you will remember him. He was an All-American baseball player, he was an All-American basketball player.

He was graduated from Duke in 1930. He went immediately into the Big League. He spent thirteen years there. He played for the Yankees, for Boston, the New York Giants, had two years or more with Cincinnati. He was in the 1939 World Series with them. He was in the 1942 World Series and hit .375.

He dropped out of baseball at the most lucrative time of his career in spite of an excellent contract because at that time he had already been to law school at George Washington University and he had gone into the insurance business in 1934 with his fa-

ther.

He has now been an insurance counsel and broker for twenty-five years. He has written extensively on this subject, has two books that are recognized almost as textbooks.

Bill, it is a real pleasure for me to present you.

MR. WILLIAM WERBER: I told Doc that was a pretty good start and he said, "Now, get on base." But, do you know, what Doc failed to tell you was that he worked on us after that Kentucky ball game and I think we beat them about 27 to 24 or 23 or something like that, and, my goodness, what a score in comparison with the scores today. And, do you know, after he worked on us we went out and lost the final game, so I don't know whether it was an asset to have him do the work on us or not.

Actually, I am delighter to be here and delighted to have the opportunity to talk to you, gentlemen, because I more or less consider myself a converted North Carolinian. My father had the very good judgment to send me to North Carolina to become civilized and educated, and in turn I extended the same favor to two or my three childrn. Bill graduated from Duke in 1953 and is now in business with me, and Patricia graduated in 1956 and is now married to a young doctor at the Duke Hospital.

I have a younger daughter than Patricia who already has put in her application with Mrs. Persons for her sister's corner room. I merely mention that to indicate that I am very happy to be in North Carolina because it does hold a very dear spot in my heart.

This Jenkins-Keogh Bill might take a little preliminary explanation. One of the reasons why legislation has been repeatedly introduced in the House to put this Bill across is the great incidence of employee retirement plans in industries of all sorts. The labor unions have been particularly active in forcing these plans into existence in practically every industry. Those employers not connected with unions at all or any labor movements have felt it to be a good business practice to institute these plans so a very large segment of our working population is today covered under retirement plan benefits.

These are of particular advantage to employees, and for this very simple reasoncertain tax advantages have been given the institution of pension plans. For example, the employer can deduct his contribution to the pension plan as a business expense. When the employer makes his contribution to a pension plan it does not become taxable income to the individuals for whom the contributions go. The money put into the pension fund accumulates on a tax-free basis. As a result an individual under a pension plan can therefore build up a tax-free lump sum of money for his eventual retirement at a much more rapid rate than can an individual such as yourselves or individuals such as yourselves. Normally, in even the low tax brackets, twenty to twenty-five per cent, the accumulation under a pension plan can be built up approximately three times as fast.

So it is of particular interest to you, gentlemen, to have the Keogh-Simpson Bill—as it is now called—passed because it is of tremendous advantage to you.

Under the Keogh-Simpson Bill, a doctor is permitted to contribute up to ten per cent of his net income. In other words, if a doctor has a net income of \$8,000 he can contribute up to \$800 in some restrictive type of investment program. Primarily this restrictive type of investment program, as Dr. Caldwell has already mentioned, is primarily

connected with different types of insurance contracts and different types of investment vehicles managed by trust departments and banks.

A doctor is limited in the amount that he can put into the fund up to \$2,500 a year, so the maximum net income that he could use would be \$25,000. As much as can go into this fund is \$50,000. Those are the highlights of this Bill.

There are a lot of other things in connection with the Bill that you can spend quite a bit of time talking about. What happens if an individual dies? The money of course is available, assuming a doctor is in there and the doctor has a widow. The widow is entitled to receive the accumulated fund either on the basis of a lump sum or she can have it spread out over a five-year period; or if the money is in the hands of an insurance company she can receive that in the form of an annuity income for the continuation of her life. If it is in the hands of a trust department of a bank, the trust department of a bank can, of course, go out and buy an annuity for her and thus spread the amounts to her over the period of her lifetime.

I think you, gentlemen, might be interested in the financial consequences of the Keogh-Simpson Bill as it may apply to you.

This is the situation today in connection with the saving of money in so far as doctors are concerned. For example, if a doctor has a net income of \$8,000—and this is on the basis of a joint return—the income taxes paid would be \$1,680, the doctor would, of course, be in the 26 per cent bracket. The doctor earning a net income of \$8,000 wants to save \$1,000. He must use \$1,350 of earnings in order to save \$1,000, and the reason that that is so is because he is saving money after personal income taxes have been paid.

A doctor in a net income bracket of \$22,000 will pay income taxes of about \$6,040. He is in a 38 per cent bracket, and if he wants to save \$1,000 he must use \$1,620 of earnings. Well, to save \$1,000 you have to earn \$1,624 and above that net is quite a considerable undertaking.

Let us assume, for example, that this Keogh-Simpson Bill goes into effect. If this doctor earned \$8,000 of net income he is in the 26 per cent bracket. If the Simpson Bill is in effect he can deduct that \$1,000. In other words, before he pays any income tax at all he takes that off of his top bracket so that the net effect of saving \$1,000 in the 26 per cent bracket is \$740. Under the present system it is \$1,350, which means that the saving to the doctor, a doctor in a 26

per cent bracket, is \$610 a year. That is a

considerable sum of money.

Getting back to this chap that is in the \$22,000 net income bracket, or the 38 per cent bracket, it costs him but \$62 to save \$1,000. Under the present system it is \$1,620, which means that that doctor saves \$1,000 each and every year, so you can realize that this Bill has a very substantial financial significance.

Assuming that this legislation does pass, I think you can see the difference in savings to you in so far as the accumulation of funds is concerned, and this will put you on the same basis as employees covered under regu-

lar formal pension plans.

About three or four years ago I felt that this legislation would eventually pass because those people who are interested in it are very active in trying to persuade both the House and the Senate to pass it, and it looks perhaps, if not this year then very definitely next, that this legislation will become law. So I began to work on one of the large mutual life insurance companies to get them to design a particular type of contract that would be available for large organizations because in the event of the passage of that legislation doctors and other self-employed groups all over the country will be literally beseiged by all types of different individuals soliciting business in their particular line. All of the life insurance agents are primed and ready to go, selling their particular contract with their particular company.

If you understand really the difference in buying as an individual and buying as an organization you have to have an understanding of the mechanics of commissions in so far as life insurance contracts are concerned.

When you buy a retirement income contract with a life insurance company, unless the contract is a death benefit with a life insurance feature or a retirement annuity contract with a life insurance company, and that is a contract which provides for the return of premiums, your commission is graded in relationship to the number of years of retirement, so that doctor aged 25 buying a retirement annuity or a retirement income policy will pay a commission into the insurance company that is all figured into the loading of the contract. The insurance company would pay a commission to the underwriting agency of approximately 40 per cent,

Where a doctor aged 50 to 55 buys a retirement income or retirement annuity contract, the commission would be somewhere around

12 to 15 per cent, depending on the company that writes the contract.

This particular contract which we had this insurance company develop is based upon a commission of one per cent, so that is down very low, and it is reflected in the charge which the insurance company makes to get a given dollar of benefit at retirement.

I ran an analysis of perhaps 16 of the leading mutual companies for no particular reason. I would like to use these now just

for demonstration purposes.

Suppose a doctor is 40 years of age and he buys a retirement annuity contract with the Connecticut General, a very fine company. He buys a contract that will guarantee to provide ten years of income beginning at age 55. He would pay \$29.67 to buy that ten dollar a month income. Under this special contract he would pay \$41.70. I have not figured it exactly, but it looks to me as if that is a difference of about 20 per cent in gross outlay.

All of these are mutual contracts. In addition to the gross cost, the net cost is somewhat less because all of these companies pay dividends. So you can see the very substantial difference that becomes possible to you through joint action rather than individual

action.

I see that my time is about over. But there is one additional thought that I would like to leave with you that lends itself as a possibility in connection with the development of these restricted retirement fund

programs.

The amount that goes into the annuity portion of the program-and I am assuming here that the amount of money that goes into an endowment contract or an annuity contract is a deductible expense. Now, if a doctor wishes to use a retirement income contract he can do so. That is a contract that has an insurance feature. That portion of the dollar that he pays that goes for the cost of the insurance protection is not a deductible expense. He cannot charge that off. There are many variations of the use of insurance in connection with a program of this sort. For example, the doctor might be interested in having a program with reducing term insurance as these cash values build up. A program should be worked out that would provide level premiums for this reducing term. In other words, for each year of the ten dollars a month income that you buy you could have a death benefit at the start of \$1,000. As that cash value builds up —let us say the cash value at the end of the first year is \$25, then the amount of insurance would be \$975. The next year the

cash value might be \$65; the death benefit would of course be \$935. That lends itself as

a possibility.

I am not going to conjecture on the possibility of the Bill passing this year. Senator Byrd is Chairman of the Senate Finance Committee. He is sitting right tight on top of these purse strings, so this year it may get by or it may not. But it passed the House by an overwhelming majority, and certainly I think your Society has been very wise in setting up a committee to study the Bill and to watch its progress.

Incidentally in closing I will say that whether the Bill ever passes or not, this is a program that is available to doctors today. In other words, if your State Society decided that it wanted to go into a program of savings on a collective basis, they could do so today, and they could use the advantages of this low cost contract which is in ex-

istence.

It is a pleasure to be here with you, gentlemen, and I hope I have touched on a point or two that has been of interest to you. (Applause)

DR. CALDWELL: Thank you, Mr. Werber. We certainly appreciate your coming to us from Washington and bringing us this educational service on this matter.

Our next speaker, Mr. George Thomas Lumpkin, Jr., Trust Officer of the Wachovia Bank and Trust Company of Winston-Salem, is here as a representative of the Trust Section of the North Carolina Bankers Association and will develop the trust fund aspect

of this subject. (Applause)

MR. LUMPKIN: Gentlemen, it is a pleasure to be here and talk with you briefly as a representative of the Trust Section of the North Carolina Bankers Association. In an area so new and formative as trust thinking in regard to the Keogh-Simpson legislation, it would be impossible properly to represent the entire Trust Section. Therefore, in fairness to my fellow-members. I would like to say at the outset that my remarks may or may not be representative of their thinking. But they are representative of the thinking of many corporate trustees in our country.

As has already been indicated—and fully half of my remarks have already been made just as the result of speaking second on the subject—the chances of success of this bill during the current session of Congress are very remote in my opinion. However, I know from at least the opinion of some rather well informed sources that the chances in the 1960 session are rather good, especially if the business of the country and the govern-

ment income of the country follows the pattern that is anticipated in the next 12 months. If so, Congress will be dealing from a surplus instead of deficit and the chance of passage will be considerably better.

One of the things that is holding it up, or one of the fears of the Treasury Department, is the fact that the unions who are keeping very quietly away from this subject are simply biding their time. If this passes, then the next move is to make all contributions by all of their members to all of the plans have the same treatment. That would cost the government three billion dollars a year. That is the fear, that is the basic reason, for the Treasury's objection, not the loss of income that would come from professional men.

We have had some brief discussion of the provisions. Actually, the provisions are very likely to be changed. I have seen the preliminary run-off of the amendments which are being recommended by the Joint Bar and Trust Divisions of the American Bar Association and the Trust Division of the American Bankers Association, and if those things are passed, and they probably will be, I think it would put the trust company on a little more even keel with the insurance company particularly in the realm of the annuity payments at the end.

At present a trust fund would have to terminate in ten years, and that is one of the big arguments. A second one is the limitation on investments which is not too severe but could be alleviated to some extent.

We have heard a very good presentation of the insurance approach to this problem and a few words about the basic advantages, that is, these two charts here showing how little or how much it costs to invest \$1,000. Those advantages carry over to the retire-

ment trust program.

The retirement trust program sponsored by a bank would amount to the formation of a large pool trust where all of the funds coming in from that organization, or possibly everyone cooperating with the program, depending upon the nature of the formation of the program, would be pooled into a mutual fund if you please, to give my competitors a boost, and it would be set up in dollar units. It would not be in the form of an individual trust for each one of you but rather a large trust for the entire group.

At my own institution we have had for a good many years what we call a "common trust fund." This program would be similar to a common trust fund, and the common trust fund has had rather remarkable ex-

perience in its history.

For example, if you had placed \$10,000 in that fund—and we are not the only bank that has this fund—in 1949 and had left the money to accumulate, today you would have \$23,100. The \$10,000 is still there. There has been an average addition of 6 per cent a year and there has been an average income on your investment of 6 per cent a year. I do not mean we have earned 6 per cent in a given year. As the market has increased your dividend based on your individual investment has increased so your income would have more than doubled in ten years.

I maintain that no matter how good a program is offered it will not begin to touch that. If one had been established in 1929 and your figures taken in 1929, his product would look considerably better. The times have had a great deal to do with it.

The insurance company guarantees what it offers. I asked Mr. Werber as he sat down if the figures of the companies he is presenting are based on a 234 accumulation rate and the company may or may not be paying excess interest. Some companies are paying a half per cent excess interest rate, which would make 314. The trust fund in good times will outstrip any insurance contract. As a hedge against inflation it would be highly desirable that you consider a trust fund.

As for cost, the annuity is set up on a ridiculously low commission of one per cent, and from an insurance point of view that is a ridiculously low commission.

The trust fund which my own company anticipates formulating would have a maximum cost of one per cent under any circumstances and would have a minimum cost of approximately one half of one per cent per year so that again the cost of operation is no more; it is less.

I will try to show you some of the advantages of my side of the picture, and I will come to the conclusion in a moment that I think it would be a wise thing for many of you to consider.

Certainly the trust fund idea in my own institution is going to run into this type of plan, and this has been publicized by a good many of the large institutions already. It has been in practic in Canada for over two years. We are going to use what is called a "dual fund," and I am sure other banks in the State will do the same thing. It will consist of one fund of stocks, the other fund bonds. You can put into each portion of the fund whatever percentage of your contribution you choose, that is, if you want to be heavy on bonds that is all right; if you want

to be heavy on stocks that is all right. You can change annually and make your next 12 months' contribution go a different way.

Our investment procedure on this type of investment will be considerably different from that which we would employ in dealing with widows and orphans. Their income is of extreme importance, and you would have to take a most conservative approach. Our intentions here are to go in a little more for the growth type of security, the type of thing that should produce capital gain which is what you want. All you can contribute is \$50,000. If inflation continues \$50,000 may not do you much good on retirement unless that money has followed the market trend.

It would occur to me that a very sensible type of program for any professional man to consider is somewhat the idea suggested by Mr. Werber at the end of his remarks. I don't know that his product or mine has all the answers. His has the answer of security, the guarantee of being there whether you live or not. Mine has the advantage of considerably greater return, the possibility of hedging against inflation. It has the advantage that there is no fixed commitment, that is, if you have a bad year and don't want to make a contribution you don't make it. There won't be any obligation to make a contribution each year as you would have in paying a premium on a policy. So they each have distinct advantages. Of course I am prejudiced. However, as I say, I think each has its advantages. You don't have to put all of your deduction in any one medium. You can distribute them around. You could have a trust with a bank, whether it be mine or another. You could have one or more insurance policies with one or more companies so that you don't have to follow any fixed pattern as long as your total deductions don't exceed the limit which has been discussed, that is, 10 per cent on \$2,500.

I know one rather able insurance man in the State who is promoting an idea of a \$50,000 policy coupled with a retirement program in a bank, the principle being that if you live you have got it. You take advantage of the inflationary hedge that the trust company offers and you have the advantage of the insurance.

It would occur to me that perhaps the \$50,000 flat insurance would not be necessary as concerned with this plan. It might be that you would want to take a reducing type of insurance which would cover the difference between the value of your trust fund and \$50,000 or the difference in the

value of your trust fund plus the cash value

of your insurance if you please.

The trust companies in North Carolina will be in this field very heavily. I know of three which are making very distinct plans similar to the ones that I have suggested. There

will undoubtedly be many others.

I would like to say one other thing, that I don't think any trust company will cut out the individual, that is, if you want a trust of your very own you can have it for a price. But I think that the rates, the costs involved, just as the cost of this special annuity is some 20 per cent less, so the cost for an individual trust would be considerably more than the cost if you were involved in a group or a pool fund.

In our own institution it would be the difference between 10 dollars a thousand and 50 dollars a year minimum, so that we will not shut the door on you but we certainly would encourage you to work as a group because as a group you can work out your common objectives and the trustee can invest in order to meet your common needs.

There is one other thing that I would like to pass along. I don't believe this will be any expensive trust agreement or expensive legal document to prepare. If the Medical Society would choose to set up its own plan then there would be one large, comprehensive agreement which would be an expensive and lengthy legal document. Individually you would come in on what would be called a "certificate of participation" which would be a form sheet that you would sign and with little or no expense. So I don't believe that the mechanics will prove expensive.

The program can be worked out for you gentlemen if this legislation passes—and I think it will pass; it is a matter of time—and I believe it will be a great bonanza to you and if handled on a group basis it can be a real profitable venture for a bank because the investment mechanics, the accounting mechanics, and so on, are already there, and we can work and handle the additional

departments.

For example, in our own institution we are already handling over six hundred million dollars worth of money that belongs to other people in trust assets alone so that the additional money here will not create for us a problem that is beyond the scope of the ability of our investment unit. That could be a problem in some cases.

Gentlemen, I recommend that you follow this legislation as far as following up your own Senators is concerned. Both of our Senators are committed to vote in favor of this legislation if the time comes for them to offer a vote.

If you have any influence in the Senate Committee, then please use it because there is where the Bill is likely to die.

Probably from an economic point of view you as a group represent the group that would profit the most as one group, but certainly the people involved in this entire area stand to be better off individually and collectively if this legislation passes.

The thing to do individually is to urge Congress in any way you can and through your organization to urge passage of the Bill. If the Bill passes then my institution and others like it will be ready, willing and able to help you take advantage of it. We have a good product to sell. It is not the only way to answer the problem—the insurance company does too, but we have a place, and we will look forward to being of service to you if and when the opportunity arises.

DR. CALDWELL: The importance of this legislation is so great as to be inconceivable at this time. It will encourage through its definite advantages participation by almost all of our physicians, many of whom at the present time are making little or no provision for their retirement security.

I consider it a privilege to be the one to present this matter to the House of Delegates

for consideration.

On January 11, 1959 a special committee was appointed by President Lenox Baker to follow the proposed legislation. This committee has been active and has considerable information pertaining to various aspects of the insurance program. It has compiled considerable information pertaining to various aspects of retirement programs. Banks, insurance companies, investment managers and estate planning advisers have been contacted and a good working knowledge has been obtained about what services will be available should the proposed legislation be adopted.

The Canadian Medical Retirement Savings Plan, which is now in its second year and is sponsored by the Canadian Medical Association, has been carefully studied as a practical plan now in operation. The A.M.A. has supplied additional information on the

matter.

As mentioned by our speaker, participation in plans as a group offers substantial advantages due to the economies available as compared with individual participation in plans. This is the case for both the insurance-annuity type plans as well as the trust fund plans.

In order to be prepared to implement the

provisions of the Keogh-Simpson Bill, should it be enacted, so as to obtain the advantages of participation the very first year, your committee has already formulated a tentative framework for a Society-sponsored program to be considered by the Officers Executive Council and House of Delegates.

As now visualized, the Society should sponsor a program for its members which will allow for two approaches to savings for

retirement.

1. Participation by payment of premiums for a restricted retirement annuity contract with a leading life insurance company.

2. Participation by making deposits into a restricted retirement trust fund operated by a leading bank in the State. Participation in each element of the plan is to be provided to the degree of individual prference (e.g., 50-50, 70-30, or 90-10 per cent) and can be changed from time to time.

The advantages of the annuity type plan

are given as:

1. Possibility of combining the annuity with needed life insurance.

2. The guarantee of a fixed return on

the investment.

3. The fixing of the annuity rate at

the present age and date.

The advantages of participation in a large

trust fund plan are given as:

1. Benefiting from the economies available from the operation of a large statewide fund as compared with one of many smaller funds. (The trustee's charge decreases as the size of the fund increases.)

2. Better position for average and con-

tinuous buying of securities.

- 3. More suitable for wider diversification of holdings.
- 4. A hedge against possible continued inflation.
- 5. The possibility of benefiting from the steady healthy growth of the holdings over a long period of time.

6. The benefits of compounding of income received from securities in the fund.

7. The compounding of the benefits other than income which should be substantial over a long period of time.

The committee recommends that this Society take action which would endorse the Retirement Program mentioned in principle and authorize the committee to act on behalf of the Society to implement the provisions of the Keogh-Simpson Bill (or similar bill) if passed, for the benefit of its members.

I move that we accept the Committee report and adopt its recommendations.

(The motion was seconded. Discussion

was called for. There being no discussion, the motion was put to a vote and carried.)

CHAIRMAN KOONCE: The Nominating Committee will now meet in the George Vanderbilt Hotel.

The next thing in our program is Item 6, Public Service Commission, Dr. John Kernodle, Chairman. I am going to ask Dr. Kernodle to make his report as brief as possible. We have a lot of work here, and we want to get through in an hour.

DR. KERNODLE: Mr. Speaker and Members of the House of Delegates: I am privileged to be one of the chosen Commissioners during 1959. I want to take this opportunity to thank all the Committee Chairmen, the members of their Committees, and especially the members of the executive staff at Raleigh for the many hours of time spent in work this year.

I must single out the work that has been done by Mr. Barnes and his assistants,

Mrs. Boutwell and Mr. Hilliard.

In reporting on the twelve committees that I have, I am going to read the Chairmen of these committees as I read each committee in order.

First is the Anaesthesia Study Committee, Dr. David A. Davis of Chapel Hill, Chairman. Its recommendations are as follows:

recommendations are as follows:

1. Continuation of the Study Commit-

tee.

2. Cooperation of the State Medical Society in publicizing the findings of the five-year study.

I move adoption of the recommendations. (The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: Next is the Advisory Committee to the Board of Public Welfare of North Carolina, Dr. J. Street Brewer, Chairman, Roseboro.

Its recommendation is that the request be made of the Medical Society to continue its present relationship with the State Board of Public Welfare through its Advisory Committee. It goes on to say that it is important for the Society as physicians to know what is going on in a medical way in the Welfare Department. Likewise it is worthwhile and a benefit to the State Board of Public Welfare to have the advice and the approval and sometimes the criticism of the committee from the State Medical Society.

I move this recommendation.

(The motion was seconded, was put to a vote and carried.)

DR. KERNODLE: The Committee on Cancer, Dr. James F. Marshall, of Winston-

Salem, Chairman. This committee recommends:

That the existence of the Commission for the Study and Control of Cancer be continued for the effective use of assembled information and to study means of implementing the recommendations made in the 1958 report and to assist in their development.

I move this recommendation.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: The Committee on Child Health, Dr. Angus M. McBryde, of Durham, Chairman. The recommendation of this committee is:

Continuation of the Study Committee with the same budget from both sponsors, Medical Society and the State Board of

Health;

(2) A summary report prepared for publication in the State Medical Society

Journal;

(3) Report of this study to the A.M.A. Child Health Committee for additional publicity. (Information only: the Committee is proposing a standard report form for hospitals to obtain pertinent data regarding history of pregnancy, delivery, and conditions apparent during neonatal life.)

I move that this recommendation be

adopted.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: The Committee on Chronic Illness, Chairmaned by myself. The recommendations of this committee are as follows:

(1) Continuation of the Committee on Chronic Illness with increased emphasis given to the formation and organization of local Society committees on chronic illness. Encourage representation of all agencies and organizations engaged in either a service or educational program for the health care of the chronically ill or aged;

(2) Continue support given other agency service programs that will assist

with home care programs;

(3) Strengthen the cooperative efforts of the Joint Committee for the Health Care of the Chronically Ill and Aged;

(4) Continue working with insurance companies, both service and commercial, for expansion of policy coverage and benefits to persons over 65;

(5) Encourage some action on insur-

ance programs following the A.M.A. proposal and the action of the Iowa State Medical Society as of February 22, 1959. Also encourage our Blue Shield Committee to continue their efforts for increased coverage in North Carolina;

(6) Continue the liaison contacts of the Medical Society representatives with A.M.A., National, Regional and State programs being planned and organized for the improved health care of these two segments of our population. Maintain the leadership role already established by the Medical Society in this area of health and medical service.

I move that these recommendations be

adopted.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: The Committee on Maternal Health, Chairmaned by Dr. James F. Donnelly of Winston-Salem. Their recommendations are as follows:

(1) Continuation of present budget for conducting the third 1,000 maternal

death study.

(2) Continued emphasis given by physicians and health departments for improved pre-natal care.

Ì move that this recommendation be

adopted.

(The motion was seconded by Dr. Sams. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: Next is the Mental Health Committee, Chairmaned by Dr. Allyn B. Choate of Charlotte. Their recommendations are:

- (1) The Committee recommends increased opportunities for psychiatric training for general practitioners in seminar and post-graduate courses throughout the State.
- (2) Continued support to the establishment of Mental Health Clinics. I move the adoption of these recommendations.

(The motion was seconded, was put to a vote and carried.)

DR. KERNODLE: The Committee on Occupational Health, Chairmaned by Dr. Harry L. Johnson of Elkin. It has three important

L. Johnson of Elkin. It has three important recommendations as follows:(1) Medical Society to support and cooperate with the A.M.A. Congress in

planning and promoting the 1960 Annual meeting to be held in Charlotte.

(2) Cooperation of the Public Rela-

tions Committee in assisting with publicity for this meeting.

(3) Full cooperation given the National Congress group by the Medical Society's Committee on Occupational Health.

Added to these recommendations, the Executive Council recommended that Dr. Johnson and his Committee apply to the budget for funds for entertaining these dignitaries who will be in our midst in 1960, and I move the recommendations.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: Already spoken of in the morning session was the action of the Committee on Polio headed by Dr. Samuel F. Ravenel of Greensboro. He did an excellent job, and we commend him accordingly. There is no recommendation for action.

A Committee on Physical Rehabilitation chairmaned by Dr. George Holmes of Winston-Salem does not have its report in the

compilation, but it will be added.

I come next to the Committee on Veterans Affairs, headed by Dr. Samuel L. Elfmon of Fayetteville. This is a very important action we bring to you today because of the reaction of the Veterans Administration Program on the Intermediary Home Town Medical Care Program that we in North Carolina appreciate. This past week Dr. Elfmon and Mr. Crawford of the Hospital Savings were in Chicago trying to negotiate a new contract. We at this time have 2,075 doctors in North Carolina participating in the Veterans Administration Program of Home Town Medical Care. We have also had the comparably unique position to be one of 8 State societies that joined in an intermediate setup. This set-up is involved to the point that Hospital Savings received all applications for funds for the treatment of these patients and they in turn make payments to the doctors for the same.

The Veterans Administration is now asking that we dispense with this intermediary service and take all requests and claims into the Regional Veterans Office. In North Carolina that would be in Winston-Salem. The Veterans Administration Committee of the A.M.A. has been opposed to this action and has asked that we go on record as favoring continuation of the intermediary program and that North Carolina continue in the same fashion of having an intermediary on the Home Town Medical Care Program. The Committee did not get far with the negotiations and therefore at the present time have rejected the proposed contract and have asked the following:

"After rejecting the proposed contract offered by the Veterans Administration, we request support and recommendation by the Executive Council in May 1959 as to not accepting the new contract, but to maintain the Hospital Saving Association Intermediary Program. We ask that you give us support of this measure and realize the implication of what it actually means."

I therefore move that we endorse their recommendation and back them in their ac-

tion.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

DR. KERNODLE: I should like to refer back to the Committee on Chronic Illness on which I have already reported. It includes heart, tuberculosis, cancer and aging. As Chairman of this Committee, I would like to give special credit to the Subchairman of the Committee on Organization of Society Committees on the local level, Dr. Emery T. Kraycirik of Burlington. We have had much activity, as I mentioned this morning.

Mr. Speaker, I now move the adoption of

the report as compiled.

(The motion was seconded by Dr. Sams. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Next is the Committee on Grievances. Do you have anything to report on the Committee on Griev-

ances?

(Nothing additional.)

SPEAKER KOONCE: Do I hear a motion that the report of that Committee as it is in the compilation be accepted?

DR. SMITH (Guilford): I so move.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

COMMITTEE ON GRIEVANCES

Several grievances have been referred to the Grievance Committee during the past year but none appeared to be of sufficient importance to call a meeting of the committee. The same plan as was reported by the committee last year was again employed. When a complaint was received by the secretary, he in turn contacted the councilor of the district in which the grievance originated. The councilor then made an investigation and reported to the secretary, after which the secretary was usually able to arbitrate the grievance by a letter to the party making the complaint. The councilors have in every instance been very helpful and have spared no time or effort. There are two cases pending that may possibly need further discus-

sion at a meeting of the committee during the next annual session.

/s/ Dr. James P. Rousseau Dr. Donald B. Koonce Dr. Edward W. Schoenheit, Secretary Dr. Joseph A. Elliott, Chairman Dr. Zack D. Owens

SPEAKER KOONCE: At this time we will have the report of the Executive Council,

Dr. Baker.

PRESIDENT BAKER: You have had distributed to you a printed report from your Executive Council. It consists of 17 pages. I am not supposed to make a motion, so I will submit this printed report to you as the report from your Executive Council.

THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA REPORT OF THE EXECUTIVE COUNCIL TO

THE HOUSE OF DELEGATES 1959

The report constitutes a summary report of the salient actions of the Executive Council meetings during the activity year of the Society beginning in May 1958 and terminating April 1959. It should be stated that the report is not an abridgement of the proceedings of the Executive Council in the form which has characterized this annual report over the past eighteen years and which formerly constituted a portion of the Annual Transactions published as a record for the membership and as a historical document. Moreover, the summary will not include the terminal meeting or meetings of the Executive Council for the activity period as the time for such terminal meeting is yet to arrive. It is presented as an obligation of the President, who is Chairman of Council, as general information and as notice to delegates of certain actions of the Executive Council under its specific jurisdiction and acting as the interim body for the House of Delegates.

First Meeting of the Executive Council Sunday, September 21, 1958

The regular fall meeting of the Executive Council, called by President Lenox D. Baker, met in Raleigh, Sunday, September 21, 1958.

The president gave a brief resume of administration goals suggested at the Annual Session and an enumeration of these in relation to progress to date. He strongly suggested to the Council his interest in disseminating third and fourth year medical students to area hospitals for training in part and of seeking out the higher intellectuals for medical career guidances in the

high schools as an obligation of member physicians.

Eighteen of the twenty Councilors and Officers answered roll call making a quorum.

By proper movement the Executive Council paid tribute to two departed medical leaders in respect and esteem of Dr. Henderson Erwin of Eureka as a member of the Council and Dr. G. Grady Dixon of Ayden and President of the North Carolina State Board of Health.

The Council accepted the resignation of Dr. Frederick P. Brooks of Greenville as Councilor of the Second Medical District and elevated the Vice Councilor Dr. William H. Bell, Jr., to the position pending action of the 1959 House of Delegates.

The Executive Council confirmed a roundrobin action of June 1958 under which it voted unanimously to elect Dr. Earl W. Brian of Raleigh to the vacated membership on the North Carolina State Board of Health incident to the death of Dr. G. Grady Dixon, and which action effects tenur for Dr. Brian only until the Annual Meeting of the House of Delegates in 1959.

Dr. Joseph W. Hooper, Chairman of the Committee on Insurances, reported the negotiations with the St. Paul Fire and Marine Insurance Company by which the proposal of a ten per cent premium reduction was granted and approved by the North Carolina Insurance Commissioner effective for the month of September 1958 incident to the group professional liability insurance carried by said Company. Moreover, Dr. Hooper reported his recommendation that his committee appoint an insurance educational committee in each of fourteen approximate highway districts in the State. Informally the Council gave tacit approval.

Dr. Joseph Hooper, Chairman of the Committee on Insurances, reported a recommendation that his committee cooperate with the American Casualty Insurance Company in relation to an additional open-period of attaining subscribers to the group program of business expense insurance in as much as the summer open period netted only 300 insurables whereas 500 was the required number to open it to all members under the agreed upon plan. Approval was given to this

recommendation.

Dr. Hooper finally reported upon a proposal for group life insurance but so many conditions and obstacles appeared to confront such a program that the Council concluded to ask Dr. Hooper's committee to give the matter more and deeper study. He also commented on the desirability for a deviation in the content of the uniform medical report forms approved in 1954 by the North Carolina Insurance Commissioner, but it appears that the form was nationally negotiated. It appeared impractical to press for the desired deviation at this time. The specimen printing of the forms authorized by the House of Delegates were announced by Dr. George W. Paschal as now available at Headquarters Office to any member requesting such specimen.

Dr. Amos N. Johnson reported to the Executive Council on the activities, extensions, progress, and proposed undertakings of the Committee on Negotiations. He referred to involved organizations outside of medicine and their concerns and suspects relative to the objectiveness of the Committee which he indicated the Committee and Society would dispel by taking the type of action that is moderate and is considerate of everyone and by negotiating in a friendly manner with business and lay people. He classified opinion inside of medicine representing three groups as: those benefiting from third party action and having an end to accomplish; a large group that are not aware of the situation of third parties and the benefits which could come of proper negotiating action, and; a group which have not practiced privateenterprise medicine and who have not been associated with everyday problems and who do not have a full concept of the problem. This two-pronged situation had led the Committee on Negotiations to the sense of much considerateness in its movements. He then outlined briefly the work of the Committee to date which was characterized by groundwork with some third parties and relating of . specific problems to be undertaken, in order, as the Committee proceeds in its authorized work. Dr. Johnson specifically reported to the Council a recommendation that the assignment of dealing with a liaison group emanating from the insurance industry be assigned elsewhere and that the initial session of his Committee with the liaison group indicated fertile ground for work for the Society. Considerable discussion clarified the real limitations of the Committee on Negotiations as to function, its authority, and responsibility to the Executive Council and to the House of Delegates. The full implication of the responsibility of clearing with the Council on objective and with the Council and House on reports and recommended action were recognized in the discussions. and by a formal action directed that the Committee proceed through county societies when the problem of investigation is interrelated. Finally Dr. Johnson reported for the Committee the decision to dispense with the

services of a paid Executive Secretary to the Committee and asked the consideration of the Council that the performance be assigned to the Executive Director of the Society and that extra areas of expense involved be assigned to the Committee's special budget and that the staff of Headquarters be utilized freely in the contributed coordinating effort of the Executive Director and his facilities. It was agreed as a proper procedure that copies of all correspondence related to the activity of the Committee would clear Headquarters and the office of the president. The Council approved a ten point agenda of items to be negotiated in future agenda with organized representatives of hospitals in the State. In the connection therewith it was agreed that collary negotiations should be undertaken with each of the Blue Cross and Blue Shield agencies in the State.

Mrs. Paul Johnson, President of the Auxiliary to the Medical Society, appeared before the Executive Council and presented an extensive and important program projecting the role which would characterize the Auxiliary work for the year. Important features of the report concerned the staging of a legislative assist during the year. The report

was informally accepted.

Dr. Jacob H. Shuford appeared in representation of the Committee on Blue Shield which had been authorized to integrate the Hospital Care Association into the administration of the Doctor's Program of Insurance by actions of the Executive Council and of the House of Delegates at the 1958 Annual Sessions; however, his Committee had noted the conditional stipulated authority under which this integration had been authorized and had found Hospital Care Association unwilling to accede to that conditional stipulation in agreement regarding board structure of Hospital Care Association under which the underwriting features of the Doctor's Plan of Insurance assumed by the participating members were safeguarded. Therefore the Committee on Blue Shield had not been able to integrate Hospital Care into the administration of the Doctor's Plan, unless in doing so it should disregard such safeguards. He asked that the Council consider and give specific directions as to the course the Committee should take.

In this connection the Executive Council heard Dr. Alfred Hamilton as a representative speaking for the four physician members of the Board of Trustees of Hospital Care Association in which he gave the view that the existing statement of agreement between the Society and the Hospital Saving

Association and its interpretation by the Committee on Blue Shield had resolved into a matter of semantics. Moreover, he indicated that Hospital Care Association involved a different type and method of election of Board structure representation and expressed the surety of opinion that Hospital Care Association would not change that method. He assured the Council the Hospital Care wanted to sell the Doctor's Program and desired to be a Blue Shield Organization and that they petition that the statement of understanding now existing could be altered in one item only which would allow the present lay members of Hospital Care to be elected as they are by the (corporate) menibership, leaving paragraph two of the statement of agreement intact and leaving the control of the program in the hands of the Blue Shield Committee. Dr. J. Street Brewer supplemented Dr. Hamilton by reading a proposed amendment to substitute for existing statement of agreement, paragraph three, which was designed to leave Hospital Care Board structure the same as prevailing at present, but to assure comprisal of the Board to one-third of the total as Medical Society representation. The Executive Council took formal action to reaffirm the action of the House of Delegates wherein stipulated authority to the Committee on Blue Shield to integrate Hospital Care Association into the administration of the Doctor's Plan was expressed in the actions of the House.

After-discussions related to Hospital Care Association integration in the administration of the plan drew from Dr. Jacob H. Shuford the expression of willingness to resume negotiation and arbitration with Hospital Care any time the Council should request it or direct it; Dr. Alfred Hamilton, speaking for the four members elected to the HCA Board, said the members are purely and simply representatives of the Medical Society and would function as such, but that there were many functions as board members that have nothing to do with the Medical Society, and; President Baker assured these board members of their legal status as elected representatives of the Medical Society and suggested inter-board visitation between Hospital Saving and Hospital

Dr. Ernest L. Strickland, succeeding Councilor of the Fourth District to Dr. Henderson Irwin (deceased), presented a statement to the Council indicating his physical inability and lack of vigor to carry on as Councilor and asked that the Council accept his resignation and offered suggestions as to his successors, both as Councilor and as Vice Councilor

cilor from which position he moved recently. By formal action of the Executive Council the resignation of Dr. Strickland was accepted and Dr. Beddingfield of Stantonsburg was elected to fill the unexpired term to meeting of the House of Delegates and Dr. Charles Parker of Wilson was elected to fill the unexpired term as Vice Councilor of the Fourth District. Tributes were paid to Dr. Strickland by President Baker, whose several years of community association with him had lead to great admiration, and by Mr. James Barnes, whose personal physician Dr. Strickland had been for many years, for the esteem held and respect for his medical judgment and guidance. (The Council rose in a body in respect to Dr. Strickland.)

In respect to a vacancy in the Vice Councilorship of the Second Medical District due to resignation of Dr. F. P. Brooks and the elevation of Dr. William H. Bell, Jr., to be the Councilor, the Executive Council authorized the President to choose from the counties involved a Vice Councilor in deference to the rotation suggested by that district and to have such candidate confirmed as the electee of the Council for the interium term to the meeting of the House of Delegates.

The Council heard a report from Dr. David M. Cogdell as Chairman of the Committee on Medicare in regard to a briefing conference held in Washington on August 8, 1958, by the Office of Dependents Medical Care relative to a cut back in services through civilian physicians and facilities due to diminished appropriations from Congress and an edict from Congress that ODMC utilize the maximum available military post facilities. He pointed in retrospect to the September renegotiation of the Medicare Contract elaborated on the basis of a continuing program of normal propostions in the event of the next Congress should see fit to restore appropriations. This would obviate the necessity of further negotiation during the fiscal year. He referred to the conditions of the cut back regulation which had been tentatively announced by ODMC and that it would markedly influence the amount of service rendered, particularly where dependents lived with the sponsors in and about service posts. Dr. Cogdell referred particularly to the effort to negotiate an indemnity contract in lieu of the service contract in conformance with the mandate from the House of Delegates that such effort be made. He reported that Colonel Floyd Wergeland received it considerately, but suggested his inability to act favorably under the existing directive under which he administers Medicare and a further suggestion that

the documented request be presented instead to Dr. Frank B. Berry. Assistant Secretary of the Defense Department, who would have the duty to bring it to the consideration of the medical advisory establishment of the Department and an ultimate decision of the Defense Department and an expressed directive from the Secretary of Defense. There is some thought that an indemnity program might be undertaken as a demonstration at some points in the country, but nothing definite could be determined at this time. The document had been prepared by the Medicare negotiating team and presented to Dr. Frank B. Berry, in person. By formal action the report was accepted.

Next ensued a discussion of the need for a relative value scale of expressing medical charges for relative conditions and service programs to guide various committees and the membership in the matter of medical charges in this State. Dr. Cogdell indicated that it would constitute a great help to his committee in negotiating affairs: so, there was an informal reference of this matter to the Committee on Blue Shield with authority to study the question and report to the Executive Council at a future date.

The Committee on Public Relations reported through the Chairman. Dr. Edgar T. Beddingfield, the growing sense of the membership that public relations has not the proper connotation for the Society's activity. The Committee agrees the entitlement needs revision and promised a later report of study of the matter. He referred to the major project. recommended. of conducting an officers workshop conference in mid-year for the officers, committee chairman of the State and component societies and outlined the proposed content of a program. Otherwise he referred to the projects of the Committee outlined in the annual budget requests. The Executive Council formally approved the report and the projects involved therein.

Dr. J. W. Roy Norton discussed with the Council problems related to his office as State Health Officer and State Registrar of Vital Statistics under the law and the experience under which there is lack of cooperation in compliance with provision of the law in reporting births and deaths either of which involve physicians as such. He was able to demonstrate marked lag and enumerated a four point category of reasons accounting therefor, as well as other lessor reasons, some of which involves other parties in the reporting of vital statistics than physicians. Dr. Norton referred to a period of improvement in reporting during the regime of Dr. Donald B. Koonce when the Society made an educational effort with the members to bring up the level of reporting. He suggested an outline of procedures which should improve vital statistic reporting at this time. The Council took formal action to disseminate information to the county society officers calculated to rectify the complaints regarding reporting. The Council also authorized the Executive Director to communicate with the association of funeral directors in the State to develop an improved understanding on the problem.

President Baker brought attention to a communication from the Governor of North Carolina relative to early preparation, in form, of legislation to be sponsored in the 1959 session of the North Carolina General Assembly and in connection therewith mentioned the authorized poliomyelitis immunization bill which Dr. Sam Ravenel is already working on and radiation protection legislation which has been counseled on during the summer. Dr. Baker also brought to attention a reference by the National Science Foundation regarding this Society's cooperation in research at North Carolina State College concerning the relation of vision to accidents and the collaboration of the Society with the Optometric Society. He ventured a correction that the latter was not true, as information to the Council.

Dr. J. W. Roy Norton brought the postal authority regulation against shipment by postal facilities of all sources as to vaccines, cultures and serums and the fact that the Medical Society and Board of Health communicated objections to the regulation. He reported the decision of the postal authorities to abate the rule. He incidentally reported the interest of the state association of county commissioners in joining in constructive health legislative movements of the Society.

Brief reference was made to the impending 86th Congress and consideration of the Forand type legislation and Legislative Committee Chairman, Dr. H. M. Poteat, was commissioned to oppose it. Mr. Barnes made reference to the two-point statement of the American Hospital Association recognizing the need of the aged for hospitalization and expressing the belief that federal legislation would be needed. He further referred to an AMA confrence of the subject of the aging problem September 14th at which the Secretary of the American Hospital Association refuted the interpretation that it favored the Forand Bill,

Dr. John R. Kernodle as Chairman of the Committee on Chronic Illness also commented on the problems posed by the Forand type of legislation and pointed to Dr. J. F. L.

Blasingames remarks indicating the AMA placed the problems of the aging first place on the agenda of the Association. There are problems for the doctors, the third party agencies concerned with aspects of administration and people constituting prospective beneficiaries seeking a hand out. Dr. Kernodle interpolated three emphatic points developed by AMA on aging: (1) the necessity for immediate action (2) positive action and (3) the necessity for long-range action. Moreover, AMA has developed a six-point program which it requests constitutent societies to develop and effect. Incidentally five of the points were encompassed in recommendations of the Committee on Chronic Illness at Asheville and all five were adopted by the Medical Society House of Delegates. further indicated that in thought, preparation and planning with pilot programs, North Carolina is out front in the consideration of the problem of the aged.

The general proposition of generating legislative good-will with the Congressional Delegation was brought by President Baker and the Executive Council formally authorized that the President and the Executive Officers plan as seem expedient a dinner-conference function without congressional delegation in Washington.

Dr. Wayne J. Benton, Chairman of the Committee on Finance, made a report in which he stated the Committee had inspected the finances of the Society and observed the quarterly audits being carried out and particularly took note of an increase in advertising revenue by approximately 29% indicative of the strong work of the Headquarters staff. With this gain during the year and some funds accruing from 1957 accounts collected and a \$20,000 bond sale all accounts incurred and in anticipation for 1958 are in prospect of payment. He referred to the budget estimate of the Committee for the year 1959 and reported a substantially balanced budget in line with the mandate of the House of Delegates that there not be further authorization of an unbalanced budget. He referred to the component of estimates received from the various committees of the Society which enabled the Committee to formulate an approximate estimate of the Society's need. He reported a minimum estimate of the Society's need. He reported a minimum estimate of \$188,000 in revenue and that while the budget accounts estimates of expenditures are in line with this revenue estimate, it should be noted that the expense estimates are maximums. In estimating revenue he advised that the Committee had not taken into account possible revenues from Life Members under the revised Constitution. He revealed that his Committee's study indicated approximately 70 per cent of revenue was from dues; 19 per cent from advertisement; 7 per cent from technical exhibits, and; the remaining 4 per cent from miscellaneous sources. In relation to the expenditures by budget account: schedule A is allowed 21 per cent; schedule B 27 per cent; schedule C 10 per cent; schedule D 2 per cent, schedule E 14 per cent: schedule F 12 per cent; schedule B 8 per cent and schedule H 6 per cent.

He noted that schedule H was to carry a rent factor in 1959 which it had not previously carried. He concluded his report by recommending the budget be adopted as estimated. There was a discussion as to a device to assure balance to the slightly unbalanced budget. The Executive Council formally authorized the Executive Director to place in reserve of every budget account item 2.2 per cent to effect a balance at the end of the year and to allocate this reserve at the end of the year only in case the revenue receipts justified it. It was clarified that such would not apply to salaries.

Dr. Benton made reference to the investments of the reserves in government bonds and a recent national analysis indicating that for example \$10,000 invested in bonds 18 years ago today are worth \$4,800. The same amount invested in industrial stock would be worth \$23,000; in a farm \$15,000; in a home \$12,000; and in an office \$12,700. He advised the Council of the Finance Committee's plan to invest the current reserves in the future with the advice of bankers and investment authorities. The Budget Estimate and report of the Committee on Finance was approved.

There was an ad interim report on certain problems of members emanating from Davie County. Dr. John C. Reece and Dr. Lynch Murphy reporting. It was indicated that the matter should be referred to the Committee on Hospitals and Professional Relations and that in the meantime that all communications relative to physician placement be acknowledged as information pending a report of the Committee to which the problem is assigned.

In reference to the problem of membership of a physician living in one county and gaining membership in another county without having obtained permission of the Society jurisdiction where he resides, or of the Executive Council on his county society refusal. Dr. Thomas L. Murphy as Councilor of the Ninth District was instructed to notify a member that his membership was

not in line. His residence appeared in evidence of automobile and voting registration to be in Davie County.

The resignation letter of a member from Johnston County Medical Society was referred to the District Councilor for attention and effort to persuade the member to re-

An expense account rendered by a SAMA delegate in the amount of \$161.55 was approved for payment.

The Council considered a communication from the Committee on Scientific Awards in which recommendations of rule changes on eligibility for awards were suggested. The Council authorized the Chairman of the Committee on Awards to negotiate such changes under authority of the respective donors— Moore County, Wake County, and Gaston County.

Communications from the National Foundation was read and discussed, in relation to new entities now encompassed in its program, and by formal action was accepted as information.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA BUDGET ESTIMATES

January 1, 1959 to December 31, 1959 RECEIPTS: (Estimated) 188,550.00 Balance January 1, 1959 Assessment 2650 paying members* 132,500.00 Interest net (estimated on diminished quarterlies) 275.00 Sales (estimated on 1958) 800.00 Author contributions to 300.00 Revenue Unexpected (estimated) 1,200,00 Technical Exhibits (estimated on diminishment of 1958) 13,000.00 Journal Net Advertisement (estimated Local on 1958) 4,000,00 Journal Net Advertisement (estimated National 1958) 32,000,00 **AMA Remittances 1% of dues processed (estimated 1958) 625,00 Annual Banquet Revenue 700 (a 5.50 each) 3,850.00 EXPENDITURES : (Estimated) 193,215.00 Schedule A 42,331,00 Schedule B 53,338.00

Schedule C 19,860.00	
Schedule D 3,450.00	
Schedule E 26,680.00	
Schedule F 22,075.00	
Schedule G 13,570.00	
Schedule H 11,911.00	
EXCESS OF RECEPITS	
OVER EXPENDITURES	Nil
EXCESS OF EXPENDITURES	
OVER RECEIPTS	4,665.00
RESERVES: (Estimated)	11000100
BONDS: (cost value) + 63,088.00	
Increment (Series F & J	
Bonds) 2,505.00	
SUBMITTED TO COMMITTEE ON	
FINANCE	1958
SUBMITTED TO EXECUTIVE	
COUNCIL FOR APPROVAL	1958
SUBMITTED TO HOUSE OF	
DELEGATES FOR APPROVAL	1959
	1000

*Based on dues @ \$50. per member per annum (not inclusive of an anticipated new class of membership under the title of SCIENTIFIC MEM-BERS.)

**To be appropriated to Secretarial Budget A-6

-In reference to actions of the Executive Council on deficit accruing Jan. 1, 1958, this sum will be reduced in 1958.

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA 1959 ESTIMATED BUDGET ACCOUNTS

1300	ESTIMATED DUI	JGET ACCOUNTS
A. EX	ECUTIVE BUDGET	42,331.00
A-1	President, expense	
	of (travel and	
	communications)	3,000.00
A-2	Secretary, salary of	Nil
A-3	Secretary, travel of	600.00
A-4	Executive Director-	
	Treasurer, salary	
	of	10,900.00
A-5	Executive Director-	
	Treasurer, travel	
	of*	3,100.00
A-6	Executive Office,	
	Secretarial and	
	Clerical Assis-	
	tants**	15,000.00
A-7	Executive Office,	
	equipment for	
	and/or replace-	
	ments	1,000.00
*Racie	· Real for personal	maintenance and tra-
		r common carrier rate
I	with per mine and o	i common calller rate

vel @ .07c per mile and or common carrier rate and for official purposes.

**Any revenue derived from collection efforts related to American Medical Association dues and processing of same shall accrue to this itm of the Budget.

A-8 Executive office, ex-		C. INTRA-FUNCTIONAL	
pense of (12		ACTIVITY BUDGET	19,860.00
months rent, com-		C-1 Executive Council,	
munications,print-		expense of and	
ing, and supplies,		travel of Council-	
repairs and re-		ors including dis-	
placement of ex-		trict travel 2,500.00	
pendables)	6,000.00	C-2 Councilors, expense	
A-9 Bonding (in effect		of (Communica-	
to 1960)	Nil	tions, printing and	
A-10 Audit (Quarterly &		supplies)* 500.00	
Annual)	600.00	C-3 Legislative Commit-	
A-11 Taxes (salary tax)	495.00	tee, expense of	
A-12 Insurance fire, com-		(Local and Na-	
pensation and em-		tional activity) 1,500.00	
ployer's liability	165.00	C-4 Maternal Health	
A-13 Membership Rec-		Committee, ex-	
ord System (addi-		pense of (secre-	
tion to)	Nil	tarial, communi-	
A-14 Publications, re-		cations, printing	
ports and execu-		and supplies) 2,800.00	
tive aids	100.00	C-5 Cancer Committee,	
A-15 Insurable: interest		expense of Nil	
insurance and re-		C-6 Convention Arrange-	
tirement plans	1,371.00	ments Committee,	
B. JOURNAL BUDGET	-,	53,338.00 expense of Nil	
B-1 Journal, publication		C-7 Scientific Exhibits	
of	39,000.00	Committee and	
B-2 Journal, cuts for	675.00	Audio-Visual Pro-	
B-3 Editor, salary of	2,310.00	gram, expense of 75.00	
B-4 Assistant Editor,	_,	C-8 Committee on Men-	
salary of	3,600.00	tal Health 500.00	
3-5 Editorial Office, ex-	.,	C-9 Committee on Griev-	
pense of (12		ances See E-18	
months rent, com-		C-10 Committee on	
munications, print-		Chronic Illness 750.00	
ing and supplies,		C-11 Committees in gen-	
repairs and re-		eral, expense of 2,000.00	
placements)	400.00	C-12 Committee on Anes-	
B-6 Journal Business		thesia Study 400.00	
Manager's Office,		C-13 Committee on Occu-	
expense of (12		pational Health 320.00	
months communi-		C-14 Committee on Pro-	
cations, printing		fessional Liability	
and supplies, re-		Insurance Nil	
pairs and replace-		C-15 Committee on Child	
ments)	300.00	Health 1,000.00	
B-7 Business Manager's	9 - 1 - 1	C-16 Committee on Ne-	
Office, equipment		gotiations 6,000.00	
	200.00	C-17 Committee on Stu-	
for	200.00	dent AMA (Sec-	
B-8 Journal, travel for		tion & Transpor-	
(Local and Na-	900.00	tation) 905.00	
tional)	200.00	C-18 Committee on Mili-	
B-9 Taxes (salary tax)	148.00	tary & Emergency	
B-10 Refunds, subscrip-		Medical Service 305.00	
tions, etc	30.00	C-19 Committee on In-	
B-11 Roster, publication	3,000.00	dustrial Commis-	
B-12 Sales tax on Jour-		sion 305.00	
nal subscriptions			
and Roster sales.	475.00	*Includes sums authorized by Chap	ter VIII,
B-13 Transactions	3,000.00	Section 2 of By-Laws.	

D. EXTRA FUNCTIONAL			for educational
ACTIVITIES BUDGET		3,450.00	purposes produc-
D-1 Delegates to AMA			tion, distribution
expense of (3 to			and printing, bind-
each annual and			ing, stuffing and
clinical session)	1,500.00		mailing 400.00
D-2 Conference dues	200.00		E-11 News and press re- leases, production
D-3 Woman's Auxiliary			and printing of 600.00
(contribution to entertainment,tra-			E-12 Public Relations Bul-
vel to National			letin, production
Auxiliary for 2			and distribution 2,300.00
and productions)	950.00		E-13 School Physicians
D-4 Delegates to AMA			Conference, ex-
Regional Confer-			pense of 250.00
ences	300.00		E-14 Exhibits and Dis-
D-5 Delegate to SAMA,			plays: Purchase,
expense of (1			rental, production,
each Medical			fabrication and
School Chapter			transportation of 650.00
(3))	500.00		E-15 Medical Students
E. PUBLIC RELATIONS			Conference, An-
${\bf BUDGET^*}$		26,680.00	nual Officers Con-
E-1 Assistant Executive			ference 1,000.00
Secretary for Pub-			E-16 Physicians Press
lic Relations, sal-	0.055.00		Conference 400.00 E-17 Public and personi-
ary of E-2 Assistant Excutive	8,855.00		fied activities in
Secretary, travel			the field of Public
of	1,800.00		Relations 800.00
E-3 Committee Chair-	1,000.00		E-18 Collateral Public
man, out of State			Relations with
travel	300.00		other committee
E-4 Public Relations,			activities 2,000.00
Secretarial assis-			*Authorized by action of 1949 House of Delegates
tance	2,500.00		with proviso that \$15. of annual dues (estimated
E-5 Public Relations,	1 000 00		to gross \$28,000) be specifically allocated and
Equipment for E-6 Public Relations Of-	1,000.00		earmarked for support of Public Relations Pro-
fice, expense of			gram. The division allocations are estimates only
(12 months rent.			and may be changed within the total of the
e o m munications.			Public Relations Budget. By later action of the
printing and sup-			Executive Council, approved by the House of Delegates, the authority to earmark any segment
plies, repairs and			of member dues was eliminated.
replacements)	3,000.00		of member dues was eliminated.
E-7 Taxes (salary tax)	175.00		F. ANNUAL SESSIONS 105th)
E-8 Publications and Ex-			CONVENTION BUDGET 22,075.00
ecutive aids	150.00		F-1 Programs, produc-
E-9 Audio-Visual depic-			tion of 1,700.00 F-2 Hotel and Audi-
tion; photography;			torium expense 2,500.00
radio-motion pic-			F-3 Publicity promotion,
ture; production, distribution and			expense of (re-
printing, purchase			porters and ex-
of films, etc.	500.00		pense) 300.00
E-10 Educational distribu-	0.0400		F-4 Entertainment (gen-
tions; reprints,			eral involving per-
periodicals, press			sonnel 775.00
materials pam-			F-5 Orchestra and floor
phlets and dodgers			entertainment 2,500.00

F-6 Guest Speakers (5)		G-10 Organizational sur-
expense of and/or	222.00	v e y implementa-
for honorarium for	800.00	tion Nil
F-7 Banquet Speaker,	NE	G-11 Retirement systef
fee and expense	Nil	for Society em- ployees 2,300.00
F-8 Electric Amplifica-		ployees 2,300.00 H. RURAL HEALTH
tion, operators, in-		FUNCTION 11,911.00
stallations and		H-1 Committee Chair-
screening audi-	050.00	man, expense Na-
torium	350.00	tional Conference 300.00
F-9 Booth installations,		H-2 Rural Health Con-
supplies, expense,		sultant, salary of 6,006.00
signs, (scientific		H-3 Rural Health Con-
and technical) in-		sultant, travl of 2,000.00
cluding exhibit		H-4 Rural Health Func-
expense and pro-		tion, salary, part-
motion	4,000.00	time secretary for 1,302.00
F-10 Projection, expense		H-5 Salary taxes 153.00
of (service ren- tals)	500.00	H-6 Rural Health Con-
•	300.00	ferences 1 State 6
F-11 Badges (members, guests, exhibitors,		District 600.00 *
auxiliary)	150.00	H-7 Rural Health Func
F-12 Reporting Service	100.00	tion, office ex
for Transactions		pense of (12
(sessions & sec-		months communi-
tions 13)	2,000.00	cations, supplies
F-13 Rental, extra facili-	,.	and replacements) 700.00
ties, trucks for		H-8 Sponsorship in fa-
sections and/or		vor of 4-H health
exhibits	400.00	activities 400.00
F-14 Exhibitors enter-		H-9 Educational dis-
tainment (at 5%		plays and distri-
Exhibit In-		butive materials 450.00
come)	1,100.00	*Donations from health serving groups approved
F-15 Banquet expense		by the Executive Council may accrue to this item
and places for		of the budget.
members remitted	5,000.00	
MISCELLANEOUS		Dr. Harry Johnson gave a brief report of
BUDGET		13,570.00 the AMA Congress on Industrial Health
G-1 Previous accounts		which he attended as a delegate in May 1958
payable	100.00	at Washington and referred to the citation
G-2 Refunds (dues, etc.)	100.00	awarded by the President of the United
G-3 Legal Counsel, re-	7.500.00	States to Dr. Lenox D. Baker for leadership
tainer fes for	7,500.00	and contributions in the service of physically handicapped people. The report of Dr. John-
G-4 Reporting (Executive Council, etc.)	1,200.00	son was received as information.
G-5 President's Jewel	1,200.00	A letter communication from Columbus
G-6 Token, plaque and	1,100.00	
certificates, mats		County Society seeking to have the State
and promotion of		Society secure the "MD" lettered North Carolina Motor Licenses allotted to physi-
GP of year	60.00	cians alone was discussed at length. The
G-7 Fifty Year Club		Executive Council took formal action to dis-
(pins and certifi-		favor such a plan.
cates for 1959)	50.00	President Baker discussed an outline of
G-8 Sections (12) ex-		his suggestions in reference to the elimina-
pense of com-		tion of night meetings in the course of the
munications and		1959 Annual Sessions Program by these re-
printing	100.00	arrangements: (1) Hold Executive Council
G-9 Contingency and		meeting Saturday at 2:00 o'clock, continuing
emergency	1,000.00	in the evening or on Sunday morning at
	-,	in two crowned or on contact manning as

10:00 o'clock; Sunday afternoon free or audio-visual scientific program: House of Delegates Monday morning at 10:00 o'clock, reconvening at 2:00 o'clock and completing work so there is not a night meeting of the House; move the Third General Session to convene immediately after the closing of the Second General Session: extend the golf tournament over as many days as possible; have all executive annual reports mimeographed and submitted to the delegates in advance rather than personal presentations in the early part of the House of Delegates proceedings; and eliminate the long roll call. It was generally thought that a Monday night meeting may be essential to elect and form a new nominating committee to serve into 1960. The Council took formal action to approve this outline and to authorize the President to set up the entertainment schedule in line with his practical views on the matter. It was indicated that the staff and President should consult and clear with the Committee on Arrangements.

The Executive Council expressed the general view that district societies of the State Society may arrange with county society officers in the counties comprising the district that district dues be collected and remitted to the district treasurer without coming through the State Society Headquarters.

The Executive Council adjourned at four-thirty o'clock.

EXECUTIVE COUNCIL MEETING Sunday Morning, January 11, 1959, Pinehurst, N. C.

The Executive Council of the Medical Society of the State of North Carolina met at the Carolina Hotel, Pinehurst, North Carolina, Sunday, January 11, 1959, President Lenox D. Baker presiding. Invocation was rendered by Dr. G. Westbrook Murphy following which Secretary Rhodes called the roll and declared a quorum present with seventeen answering the call. Absent were Dr. T. P. Brinn and Dr. Wingate Johnson, the latter a non-voting member of the Council.

President Baker dispensed with the minutes and proceeded with the agenda. The first question called was a vacancy in the Vice-Councilorship of the Second District. On motion made, seconded and carried, Dr. Linwood Williams of Kinston was elected to the interim tenure to May, 1959, at which time the House of Delegates will fill the unexpired term terminating in May 19—.

The Franklin County proposal that Dr. Charles G. Tabor, serving a merical messionary post in Taejon, Korea, be designated as an Honorary Member under Article IV, Section 5 of the Constitution was presented, On

motion of Dr. W. A. Sams, duly seconded and carried, this class of membership was authorized to Dr. Tabor.

The substance of a proposal by the Committee on Scientific Awards was presented with the sense that there should be a broadening of the definition of those eligible to participate in scientific awards to the extent that some persons who are not medical doctors who do research (under medical direction) in the medical field and who are invited by the Society should be recognized for the competition of these papers in the awards offered by the county societies, viz., Moore County Award, Wake County Award, and Gaston County Award. The Executive Council took no additional action leaving the matter in the discretion of the Committee on Awards to work out properly with the respective donor counties.

President Baker recognized Dr. Jesse Caldwell to whom the Council, through the action taken in September 1958, had been assigned the responsibility of a primary study of the problem of trust arrangements for the medical group in the event of passage of federal legislation authorizing self-employed individual retirement as a tax deferrable operation. Dr. Caldwell referred to the annual optimum of \$2,500 income deferable trust investment and the \$50,000 maximum authorized for such retirement plan. He indicated that one would through a restrictive retirement fund or purchase of restrictive retirement policy sold by insurance companies be able to establish an individual trust. He pointed to the possible economy in arranging the trust through banks where loading of fixed charges could somewhat be avoided in the operation of the fund, particularly at the beginning, and referred to the advantages which might accrue to members investing in a group plan of large dimensions. He further referred to the adaptability of one plan over another where safeguards could be exercised in relation to inflationary trends. The larger trusts appeared to offer advantage in average buying into investments which is not available to smaller trusts. He recommended the Council take action leading to sound consideration of developing a larger trust fund for the participation of the members of the Society as an individual advantage, On motion of Dr. Westbrook Murphy, duly seconded and carried, the Executive Council recorded its favor of the creation of a trust fund arrangement upon passage of a federal act; instructing the Executive Director of the Society to so inform all county medical societies; and, that the President be empowered to appoint a committee to investigate all

possibilities and to report upon same with recommendations to the Council in May, 1959. (Immediately, President Baker appointed a Committee to Study Trust Fund composed of Dr. Jesse Caldwell, Chairman. Drs. Wayne Benton, Hewitt Rose, Paul Johnson, and Arthur L. Daughtridge providing that it serve Ad Hoc to the Committee on Finance.)

A visiting delegation from the Lenoir County Society reported for a committee related to a textbook curricular problem raised from the investigations of the Lenoir County Medical Society, Dr. Joseph Bower, President of the Lenoir Society, reported that their study revealed what is believed to be a very insidious teaching of socialism in public schools and presented a committee of three designated by the county society to present the matter to the State Society -Drs. Linwood Williams, J. C. Peele, and Ĕ. W. Keiter stood and were recognized to report severally. Dr. Bowers illustrated findings in expressing the following: "We did not particularly object to children learning about socialized medicine, but we wanted them to learn the truth about it. In these textbooks everything leads up to the fact that the Federal Government is the answer to all problems. The text have a picture; for example, of a tenant farm house, and it says, 'The farmer here lives 20 miles from town. How can he get medical care?' It goes on further: 'The answer to this problem lies in the Federal Government." Dr. Bowers indicated the textbooks have half-truths and assumptions which one is led to believe through the text, built up views and then present the answer in terms of socialism at the end, with the answer being fallacious, and this system of ideas permeate the text throughout. Dr. Bowers referred to the legend of diminishing prestige of the medical profession and expressed the sense that doctors have not contributed to this legend so much as has teachings in a planned attempt to undermine private initiative and the free enterprise system. With Council approval, President Baker designated the Committee Advisory to the Auxiliary of the Medical Society to assume a study and action program related to the problem of textbook deviations and added to the committee, Ad Hoc, Dr. Joseph Bowers, Linwood Williams, J. C. Peele, and E. W. Keiter with power to proceed in cooperation with the Auxiliary and other organizations on a rectifying program. (The assignment was accepted by Dr. Roscoe D. McMillan as Chairman of the designated committee.) On motion, seconded and carried, the Executive Director and Counselor

John Anderson were requested to make representations to some members of the 1959 General Assembly in regard to the subject of the textbook situation.

The Treasurer of the Society presented the problem of a scientific section tendering a check for \$200 obtained from a pharmaceutical firm to cover expenses of a guest speaker from the section to appear on the General Sessions program in 1959. Under existing policy authority to receive such funds, with possible implications, does not prevail. Discussion ensued tending to indicate under proper circumstances such acceptance would be in order. On motion of Dr. W. A. Sams, duly seconded and carried, the Treasurer was authorized in the event of any type of outside contribution offered to the State Medical Society to clear the propriety of receiving and processing and paying out such contributed funds with the President and constitutional Secretary of the Society and if the three agree upon it then in that event the contributed fund shall be accepted by the Treasurer.

Discussion next related to problems in the organization and projection of Scientific Work in the Sections and the need for coordination in these activities of the Society leading to improved scientific programming. The problem appeared centered about an opportunity for section chairmen and section chairmen-elect to convene together to gain value and coordination in the beginning of the planning of annual programs. On motion of Dr. Claude Squires, duly seconded and carried, the Committee on Constitution and By-Laws was asked to consider a revision under which each section would elect a chairman-elect beginning in 1960 annual sessions

Dr. Donald B. Koonce announced the action of the North Carolina Branch of the American Cancer Society in making a contribution of \$500 to the Society for use of the Committee on Rural Health incident to programs authorized by the Committee. On motion made, duly seconded and carried, the receipt and dispense of the fund was authorized.

Dr. Harry L. Brockmann appeared to report to the Council from the Committee on Nursing and presented the following resolution:

Whereas, all physicians are properly concerned with the quality, scope and availability of nursing services, and

Whereas, such services are dependent upon the performance of schools of nursing and upon the action of the examining boards which license these graduates, and

Whereas, a considerable amount of instruction given to nursing students is provided by members of the medical profession, and

Whereas, in spite of this medical participation, the body of knowledge considered necessary to pass a licensing examination and become a registered nurse is determined solely by nurses in secret session of a select group known as the Blueprint Committee for State Board Test Pool Examinations, and

Whereas, although each state may determine the passing score required by its candidates on such test pool examinations, the practical necessities of interstate reciprocity create a national standard unrelated to the local problems of the various states; Therefore be it.

RESOLVED, That the Physician's Committee on Nursing of the North Carolina State Medical Society recommend to the Executive Council of said Society that the officers of the American Medical Association be petitioned to assume an advisory role in nursing education in general and. more specifically, to immediately seek representation on the Blueprint Committee for State Board Test Pool Examinations of the National League for Nursing for the purpose of participating in the creation of the standards by which graduates of schools of nursing are judged for licensure and are thereby added to the limited reservoir of individuals rendering professional nursing service in this coun-

In discussing the resolution Dr. Brockmann indicated that in 1958 approximately 34 per cent of applicant nurses in North Carolina failed to pass the licensure examination. On motion of Dr. George W. Paschal, seconded by Dr. Ralph Garrison, the resolution was adopted by vote.

On motion of Dr. Edgar T. Beddingfield and duly seconded and carried, the Executive Council directed that the resolution be transmitted to the Board of Trustees of the American Medical Association for consideration the matter regarding influences related to the accreditation of schools of nursing. Dr. Brockmann further reported action of the North Carolina Hospital Association asking state aid for conducting schools of nursing in voluntary hospitals and reported it had requested a joint committee related to legislative effort on the subject. On motion of Dr. W. A. Sams, duly seconded and carried, the Committee was asked to pursue the mechanisms of legislative processes and to instruct the Legislative Committee of the Society to assist as needed in seeking state aid for schools of nursing. Concluding this item of consideration of the Council President Baker commended Dr. Brockmann for the work of the Committee and expressed the appreciation of the Society.

Dr. Thomas L. Murphy was recognized to give his Councilor report of investigation of the Davie County Hospital staff situation as referred by the Council in September. He referred to letter communication from the State Society Committee on Hospital and Professional Relations directed to Dr. Ralph Gambrel of Mocksville:

Dear Dr. Gambrel:

A meeting of the Hospital and Professional Relations Committee of the State Medical Society was held on January 4, 1959, at which time the Mocksville dispute was discussed thoroughly.

The decision of the Committee was that the situation in Mocksville is primarily a local problem but that this Committee would be more than willing to help you in resolving a conflict with the Board if it is at all possible. It was decided to appoint a subcommittee of three and to ask the medical staff of the Mocksville hospital to also appoint a committee of three and ask the Board of Trustees to appoint a committee of three. We will be more than happy to meet with the representatives from the staff and the Board of Trustees, sit down together and try to bring about an understanding on the part of both trustees and staff of their responsibilities in operating a general hospital.

It may well be that by this time the situation is well under control and you will have no need for our help. If you still have the problem and would like to tackle it in the manner above described simply let me know and we will try to arrange a meeting of all parties concerned.

I certainly appreciate your hospitality while in Mocksville and hope that things are going well with you.

Theodore Mees, M.D., Chairman Committee on Hospital and Professional Relations

The Executive Council generally agreed that the communication required no action. A further recommendation of the Committee on Hospitals and Professional Relations was that the State Society adopt a resolution of the Medical and Chirurgical Faculty of the State of Maryland on September 12, 1958, related to Accreditation of Hospitals and Intern and Resident Training Programs, The resolution was read. Dr. Donald B. Koonce stated that the North Carolina Chapter of the American College of Surgeons was considering the subject of accreditation and ex-

pressed the sense of the principles involved in the following motion:

I move that we approve the Medical and Chirurgical Faculty of Maryland resolution in principles, but we move that the Commission on Accreditation of Hospitals and the Council on Medical Education and Hospitals review and reconsider their objectives and their procedures and evaluation efforts, and that the opinions and findings of local medical societies be given more weight in appraising hospital facilities and services for accreditation.

The motion, being duly seconded, was put to vote and carried.

(The Executive Council recessed at 1:00 o'clock to reconvene at 2:00 o'clock.) (The Council reconvened at 2:15 o'clock.)

President Baker: Dr. Rhodes will you discuss the question of dental services as related to Doctor's Plan of Blue Shield?

Secretary Rhodes: The facts are these: "On November 11, 1958, Dr. H. M. Poteat conducted a meeting of the Committee on Legislation and at that meeting the dentists appeared. Their complaint is that dental items included in the fee schedule of the Blue Shield Plans are not payable to the dentist and as a group they have the difficulty of the subscriber being under the impression that such dental items are covered. Therefore, they have to take the time to explain to their patients that they are not covered under Blue Shield. The North Carolina Insurance Commissioner has ruled that the dentist cannot be covered under the present premium rates and that, if coverage was to be extended dental service, a separate rider would have to be attached to policy carrying its own premium rate. There is no provision in any of the Blue schedules for the coverage of dentists except that our Committee on Blue Shield under the Doctor's Program provides that the dentist who sets a fractured jaw should be paid, and some of the policies of Hospital Saving Association do pay for extraction of impacted wisdom Hospital Care Association has not made such provision in its policies to the present, though there is a consideration of Hospital Care to put into its policies payment for wiring fractured jaws and for extraction of impacted wisdom teeth." Dr. Rhodes indicated further that investigation revealed that generally dentists are not trained in oral surgery to qualify them to participate in this type of service, whereas some take post-graduate training to do oral surgery on a qualified basis. Moreover ,he reported the problem that some hospitals do not permit dentists to admit patients on their own initiative, but rather through medical physicians on the basis the patient should have medical supervision of a physician in event of general anesthesia for surgical procedures. (It was added that some physicians were reporting dental adjunctive surgery, collecting for it and remitting to the dentist which was not considered proper procedure under professional ethics.)

On motion of Dr. John C. Reece, seconded by Dr. Edgar T. Beddingfield, the Executive Council approved in principle the inclusion of dental oral surgery in the Blue Shield policies leaving the technique of the coverage and the method of payment to the Committee on Blue Shield and the two Associations to implement. Upon being put the motion carried.

A communication from the Pasquotank-Camden-Currituck-Dare County Medical Society was considered in relation to the situation under which the marriage health certificate of an osteopath was being accepted by the register of deeds in one of the counties as required of each applicant for marriage license under North Carolina Law. In the view of rulings of the Office of the Attorney General of North Carolina that the register of deeds is complying with the law, the Council took no action on the subject.

The initial consideration of the Committee on Medical-Legal matters related to a possible code of relations on autopsies between the Medical Society and the Association of Funeral Directors was reported by Dr. Beddingfield as Commissioner attending the Medical-Legal meeting in November 1958. No action was taken by the Council.

On motion made, duly seconded and carried, the Executive Council authorized that intern or resident training physicians who continue from primary medical education into, and through, training be granted the Student-Intern-Resident class of membership at the rate of \$3.00 dues per annum.

On motion made, duly seconded and carried, the rate of dues for the Affiliate Member class of membership as provided in the By-Laws continue to be set at one-half of Active Member dues, or at the rate of \$25.00 per annum.

On motion of Dr. Edgar T. Beddingfield, duly seconded and carried, the Executive Council authorized the encouragement of payment, acceptance and processing of dues payments for Life Members who may elect to pay dues prior to May 1959.

Attention of the Council was directed to the American Medical Association authorization and organization of a Division of Field Service which would in course develop communication with the State Society Officers in liaison effort between the State Society

and the AMA.

Dr. Amos N. Johnson discussed with the Executive Council the proposition of the American Medical Association regarding the Larson Report related to medical care plans and the request that constituent state societies take an action indicative of position on this report which involves the primary factor of free choice of physician by the patient covered in medical care plans. On motion of Dr. Johnson, seconded by Dr. William Bell, and carried, the Council authorized that the AMA Delegates be instructed to support the free choice of physician principle as a primary condition of all medical care plans.

President Baker recognized Dr. John R.

Kernodle.

Dr. John R. Kernodle: I read to you a resolution passed at the House of Delegates meeting of the American Medical Association in December 1958:

Therefore the Council on Medical Service ecommends to the House of Delegates the adoption of the following proposal;

That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere expedite the development of an effective voluntary health insurance or pre-payment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and pre-payment plans at reduced premium rate.

Discussion ensued tending to recognize the problem to which the action of the AMA was directed and indicating that the House of Delegates of the Medical Society of the State of North Carolina by action May 1958 approved the statement, "Encourage extension of the effectiveness of voluntary health insurance by all carriers," as a part of the recommendations of the Committee on Chronic Illness on the care of the aged. A motion of Dr. Amos N. Johnson was made to authorize the acceptance and approval of the principle involved in the AMA action and that it be referred to the Committee on Blue Shield for it to work out an implementation and recommend back to the Council a program to follow. The motion was duly seconded. Further discussion ensued to express the serious concern of the AMA that state societies act on the resolution. Upon being put the motion carried.

The Treasurer referred to the mandate of the 1958 House of Delegates that there be no deficit spending. He reported that the Society came through the year 1958 without a gross deficit expenditure of funds. He referred to the Executive Council action in authorizing the Treasurer to withhold two and one-half per cent $(2^1 \cdot 2^n)$ of each budget item in order to assure that the mandate of the House be complied with in future years. On motion made by Dr. George Paschal, duly seconded and carried, the Treasurer was directed to advise each spending group within the Society that such a withholding would be put into effect.

The request that the Committee on Child Health be granted a budget increase by the sum of \$182 for the year 1959 was conveyed to the Executive Council and the reasons therefor given. On motion of Dr. Kenneth Geddie, duly seconded and carried, the additional grant of \$182 was authorized to the budget of the Committee on Child Health.

On motion of Dr. G. W. Murphy, duly seconded and carried, the President was requested to communicate to the Trustee representatives elected by the Medical Society to Hospital Saving Association and to Hospital Care Association the fact that the subject came to discussion in the Executive Council of the Society's concern that Trustees tend to represent the views of the respective Associations rather than the views of the Medical Society in matters related to the membership of the Society.

Secretary John S. Rhodes indicated that he had complied with the Executive Council directions of September 1958 that he communicate condolences to the widows of Dr. Henderson Irwin, deceased, of Eureka and

Dr. G. Grady Dixon of Ayden.

On motion of Dr. George Paschal, duly seconded and carried, the Council voted to adjourn. (The meeting adjourned at threeten o'clock.)

Respectfully submitted, Lenox D. Baker, M.D. President

Raleigh, North Carolina April 20, 1959

SPEAKER KOONCE: Do I hear a motion that the report of the Executive Council be adopted?

DR. STROSNIDER: I move that the report be adopted as submitted.

(The motion was seconded.)

DR. PASCHAL: Mr. Speaker, I should like to speak briefly to the second paragraph on page 8 of this report. I do this in order to avoid possible complications and trouble later on. Since being here it has come to my attention that about eight years ago we

revised our Constitution and By-Laws to delete a section that had to do with the welfare of the physician in the investment of funds. We were told that if the money we had in our treasury was set aside and placed in government bonds we would not be subject to taxation. We made an effort to avoid that and consequently did place those funds in government bonds. In this second paragraph on page 8 you can see that Dr. Benton made reference to the investments of the reserves in government bonds and that a recent analysis indicated that, for example, \$10,000 left in bonds for 18 years today is worth \$2,800. The same amount invested in industrial stocks would be worth \$23,000. In a farm it would be \$15,000; in a home \$12,000; and in an office building, \$12,700. He advised the Council of the Finance Committee's plan to invest the current reserves in the future with the advice of bankers and investment authorities.

This is referred to the Committee of Finance and approved by the Executive Council.

I raise the question at this time to see if it would not be well to approve this report with the exception of that and refer it to our Attorney for his advice as to whether or not this would put us in business and make us liable for taxation on both the State and Federal level.

SPEAKER KOONCE: Will you make an amendment to the motion to that effect?

DR. PACHAL: I wish to amend that we approve the report as filed with the exception of paragraph (2) on page 8 and refer that to our Attorney for his advice, then consider it at a later time.

(The amendment was accepted by the maker of the motion, Dr. Strosnider, and

the seconder.)

SPEAKER KOONCE: Is there any fur-

ther discussion?

DR. BENTON: The Constitution and By-Laws gives the Finance Committee power to invest the funds as they see fit, and obviously we will not do anything without consulting our counsel, Mr. Anderson. But the money is still in bonds. We have instructed Jim Barnes to sell, and we plan to invest in some other ways. We will not do it by talking to Mr. Anderson. I believe he is out of order because it gives us authority to invest as we see fit.

SPEAKER KOONCE: I think it was merely a matter for public knowledge rather than questioning the report at all.

DR. PASCHAL: That was part of the

intent of my motion.

SPEAKER KOONCE: The amendment

has meen made and accepted. Is there any further question? If not we will vote on the amended motion.

(The amended motion was put to a vote

and carried.)

SPEAKER KOONCE: Next is Dr. Amos Johnson of the Committee on Negotiations.

DR. JOHNSON: There is no report in addition to the report submitted by the Committee on Negotiations. There were no recommendations made so there is nothing to discuss with you at the present time. The report stands as it is written in the com-

pilation.

I would say that your Committee has been busy this year, and we think that we have explored a considerable number of problems, and since this was the first year of organization of this Committee it was necessarily a bit slow in getting started and had to feel its way. But I can assure you that by another year it will have a more extensive report and we will have explored many areas that will be of much interest to many of you, where third parties have entered into the picture in medicine. We will have a more extensive report within another year.

I move, Mr. Speaker, that this report be

accepted.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

COMMITTEE ON NEGOTIATIONS

The Executive Council of the Medical Society of the State of North Carolina, in session on September 22, 1957, confirmed the appointment of this constitutional committee of the State Medical Society. These appointments were made by Dr. E. W. Schoenheit, who was then President of the Society, by authority granted in the action of the House of Delegates creating this committee. This action was passed by the house of delegates on May 6, 1957. The 1958 House of Delegates confirmed the action of the Executive Council which confirmed the Committee appointment. Thus the committee on Negotiations was legally activated in May of 1958.

As was anticipated, the volume of secretarial work to be done by this committee was so great that a part time executive secretary was required. Until September 1958, this service was supplied by Mr. Horace Cotton, President of Professional Management of Southern Pines. During this time it became apparent to the committee and to other officers of the State Society that this service might, more efficiently and economically, be incorporated within the services rendered by the Executive Director of the

State Medical Society, and the personnel in our Raleigh office. During September past, these changes were approved by the Executive Council and the change was made immediately. Experience, since then, has proven this to be a wise change.

Early in this first year much time was spent in clearing up technical matters of procedure as were involved in the aims, purposes and desired accomplishments of this committee. We were fully aware that this committee had powers only to investigate, negotiate and recommend. Since the committee is entirely responsible to the Executive Council and, through this council, to the House of Delegates, it was decided that proposed major areas of negotiation be cleared with the Executive Council in each individual instance. This pattern of procedure has been followed. The present members of this committee wish to point out to all members of the State Medical Society the above described policy and limitation of powers. This committee was not created to be, nor should it ever be permitted to become a high handed. "witch hunting" or persecuting committee.

Some four or five major areas of negotiations have been undertaken thus far. These will be taken up individually in this report. Each of these areas of negotiations were presented to, and approved by, the Executive Council of this society.

At the Reidsville plant of the American Tobacco Company there arose a problem concerning the ethics of the policy of this employer in supplying medical care for the employees of this plant. Certain members of the Rockingham County Medical Society felt, and so presented to this committee, the belief that this employer was going above and beyond the scope of ethics of the American Medical Association in supplying total medical care, with the exclusion of Obstetrics, to all its employees. It was alleged that certain areas of interference prevented the free choice of utilization of private physicians by these employees to obtain the fringe medical benefits provided by this company. In February of 1959 a meeting of this negotiating committee was held in Reidsville. Present were three members of this committee, medical and management personnel of the American Tobacco Company, officers and selected members of the Rockingham County Medical Society and representatives of the group which filed the complaint. After some two hours of roundtable discussion, it was determined that the interest of the company, through its policies, was not to interfere with the free choice system per se. However, the company, through its employed medical

personnel, was exercising some degree of required approval of free choice in order to forestall possible abuse in this fringe benefit service. This committee felt, at the conclusion of this session, that this problem had resolved itself to the possible satisfaction of all elements of medicine and management present. It was felt that the policy of this company might now fall within the framework of the code of ethics of the American Medical Association and our State Medical Society.

Your committee has had many sessions and much correspondence concerned with the broad and overlapping problem area of the captive specialists and the inclusion of professional service benefits within Blue Cross or Hospitalization Insurance policies. The so called captive specialists include Roentgenologists, Pathologists, and Anesthesiologists. Customarily, these specialists negotiate individually, with the hospitals concerned, contracts for remuneration for their services. This remuneration takes the form of a flat salary or, better, a percentage of the gross income of the department concerned. For the hospital to make a profit on these professional services is viewed as the corporate practice of medicine. This is unethical and in certain states has been held by the courts to be illegal. It is felt that these specialists involved should, under their own name, bill and be paid directly for services rendered. They, then, should remunerate to the hospital for the expenses involved for facilities utilized. Thus far negotiations with a committee from The State Hospital Administrators Association has failed to produce a solution to this problem. Apparently the insurance companies involved have no strong feelings either way on this proposition. Your committee will continue to give much thought and time to the end of a satisfactory settlement of this problem.

Presently all Blue Cross or Hospitalization policies sold in this state have within their framework provisions for the payment to hospitals for certain professional services rendered to or for patients by doctors of medicine. This also poses problems in the area of the unethical and illegal corporate practice of medicine. This also overlaps into the problem of the captive specialists, as was set out in the immediately preceding paragraph. It is the stand of this committee that these Blue Cross or Hospitalization policies should be rewritten to exclude all payments for professional services, Professional service payments rightly should be included in Blue Shield or professional service type policies. At present there is much resistance to these desired changes. Your committee will

continue to persue its aim.

Many diagnostic and therapeutic procedures utilized in the practice of medicine, now covered in most pre-payment medical service policies, require hospitalization as a prerequisite to payment for these services. It is held that many of these procedures might be done equally well, if not better, on an outpatient basis in the offices of private physicians or in the hospital out-patient department. In many states, when the requirements of hospitalization has been deleted from these policies, it has been shown that much is to be saved. By eliminating charges for unnecessary room, board and laundry of hospitalization connected with these procedures certain areas have been able to prevent annual premium rate increases and, in instances, have produced a lower premium rate. Much of the problem of overcrowding of hospitals and shortage of hospital beds may be attributed to this unnecessary and wastefulness in hospital admission requirement as a criteria for medical benefit payment. If the estimated twenty-five per cent of hospital bed misuse and abuse not recognizable were eliminated, millions of dollars of capital outlay for additional hospital beds might be saved the public. Many valuable man hours of labor and executive time are now lost by this unnecessary and wasteful required use of hospitalization. To eliminate this costly loss of time by valuable personnel, big industry already is demanding and is receiving more such outpatient benefits from its insurers. There are certain definite areas of organized resistance to this movement. Your Committee thinks it is showing and will make progress in the right direction in negotiating the elimination of the criterion of admission in order to qualify for medical benefits.

Other matters of much lesser importance have been called to the attention of our committee. These were purely local matters and were of no state wide importance. All were handled locally without controversy. None involved problems of major policy or ethics and have resulted in amicable development in the community involved.

Within the near future, with the consent and support of the Executive Council, we plan to explore other areas of problems which have been brought to the attention of the committee

This report is submitted for your information, and we trust it will gain your approval.

/s/ Amos N. Johnson, M. D., Chairman William F. Hollister, M. D. Theodore S. Raiford, M. D.

COMPILATION OF ANNUAL REPORTS

ADVISORY AND STUDY COMMISSION REPORT

Dr. J. H. Shuford, Commissioner

The Commissioner of the Study and Advisory Group of Committees of the North Carolina State Medical Society, being uninstructed and feeling rather vague as to his duties, respectfully submits the following report. The Commissioner attended meetings of four Committees under his Commission and one meeting of the Committee on Negotiations.

Summary of Committee Activities:

1. Medicare Committee: Dr. Dave Cogdell, Chairman

(a) Attempts to negotiate with the Federal Government on an indemnity basis were not successful.

(b) A revised Fee Schedule was negotiated and became effective 1 December 1958. This schedule was negotiated on the basis of the complete program as it existed priod to 1 October 1958.

(c) Total payment to physicians increased almost half a million dollars in 1958 over 1957 to a total of \$1,498,542.05.

Recommendation: That the Society continue to contract with the government in the operation of Medicare.

2. Student A.M.A. Affairs Committee: Dr. Ike Harris, Chairman

(a) Establishment of Student A.M.A. Section of the House of Delegates.

(b) Dr. Monroe Gilmour invited to address Student Section in General Session.

(c) Transportation for Senior students arranged and financed by Medical Society. Evening meal on Monday paid for by the Society.

(d) Chairman and first vice-chairman appointed as Delegates (non-voting) to the annual session with all expenses paid by Society.

(e) The President of the North Carolina State Medical Society has agreed to give an address of welcome to the students in General Session.

Recommendation: That the Student Section become an integral part of the State Society meeting, and that the Student Program be developed further.

3. Industrial Commission Committee: Dr T. B. Dameron, Chairman

- (a) Work with the Commission has been harmonious.
- (b) There were few contested cases.

(c) Legislation:

- SB-53—proposal to allow cases, dissatisfied with disability rating given by physician, to undergo an additional examination by another physician at the expense of Industrial Commission. This bill is opposed by the Committee.
- Unnamed Bill: Proposal to place City and County officials under Workman's Compensation. The Committee opposes this legislation.
- (d) Recommends endorsement of N. C. Orthopedic Society suggested rating guide for disabilities of upper and lower extremities, along with guide for rating backs.

(e) Recommends alteration in award for amputations of upper and lower ex-

tremities.

(f) Recommends that the physician, in Workman's Compensation cases subsequently receiving liability from third parties, be not bound by fee schedules and be allowed to charge usual fees.

Recommendation: That the above recom-

mendations be accepted.

4. A. M. E. F. Committee: Dr. Harry Johnson, Chairman

(a) Recommends continued solicitation by mail.

(b) Contributions may be made to AMEF or to school of choice.

(c) 1958—138 N. C. physicians contributed \$4,225,00.

(d) 1958—42 county auxiliaries contributed \$1,083.89.

(e) 1957— the three Medical Schools in North Carolina received in grants from AMEF \$21,882. (1958 figures not yet available)

Recommendation: Increased participation of voluntary contributions to AMEF.

5. Medical Credit Bureau Committee: Dr. Howard Wilson, Chairman

- (a) Publication of Dr. Wilson's 1958 report to the House of Delegates in the North Carolina State Medical Journal.
- (b) Voted not to allow any exhibit at the annual sessions by uncertified commercial collection agencies.
- (c) Voted to have a display of recognized Credit Bureaus at the annual session for educational purposes.

Recommendation: That the Committee be continued, and that its work and scope be enlarged.

6. Blue Shield Committee: Dr. Jake Shuford, Chairman

(a) New Fee Schedule distributed.

(b) Failure of Hospital Care to qualify as a Blue Shield Agency due to disagreement over Board structure.

(c) Consideration of Dental rider, to be offered to clients on a voluntary basis, after details of procedures, nomenclature, and fees are worked out.

(d) A proposed Senior Certificate for those over 65 years of age in income brackets \$2,000.00 (single) — \$3,-000.00 (couple). Discussion with action tabled for further consideration.

(e) Creation of District Sub-Committees on Blue Shield to act as information, guidance, education, and grievance

committees on district level.

(f) Physician participation in Doctor's Program approximately 52%. Approximately 87,000 individuals covered by Doctors Program with a large majority carrying the Surgical Rider and not the Medical Rider.

(g) Hearings were held with Opthalmologists, EENT, and Dental representatives as to nomenclature and fees for

new procedures.

Recommendations:

That the Senior Certificate be considered carefully, implemented, and acted on as quickly as possible.

2. That the Dental Rider action be con-

sumated and placed on sale.

In addition to activities as noted above, the Commissioner acting by authority of the Executive Council, set in motion the formation of a relative value fee schedule for the Medical Society of N. C. Drs. Everett Bugg, Louis Roberts, and Alfred Hamilton were appointed to carry out the details, with Dr. Bugg as Chairman of the parent committee. Attached is a list of the sub-committees in the various specialties which have been appointed to assist in establishing the Relative Value Fee Schedule. It is believed that the Relative Value Fee Schedule should be ready to be presented to the Executive Council and the House of Delegates at the May meeting in 1960.

/s/ J. H. Shuford, M. D., Commissioner

Sub-Committees for State Medical Society Relative Value Schedule

Medicine
 Dr. Bert Parsons (chm.)
 Dr. John L. McCain, Wilson

Dr. Joseph Hitch, Raleigh Dr. George W. Crane, Durham

Radiologu

Dr. Thomas Thurston (chm.), Salisbury Dr. William Sprunt, UNC, Chapel Hill Dr. Joe Frank, Jr., Ahoskie Dr. James Raper, Asheville

Orthopaedics

Dr. Julian Jacobs (chm.) Dr. Chris Siewers, Fayetteville Dr. George Miller, Gastonia Dr. Walter Watts, Asheville

Ob. - Gyn.

Dr. H. Fleming Fuller, Kinston Dr. Ledyard DeCamp, Charlotte Dr. Ken Podger, Durham Dr. R. Vernon Jeeter, Plymouth

Urology

Dr. G. Aubrey Hawes, Charlotte Dr. John Rhodes, Raleigh Dr. Preston Nowlin, Charlotte

E. E. N. T.

Dr. John S. Gordon, Charlotte Dr. Larry Turner, Durham Dr. Ralph Arnold, Durham

Neuro-Surgery

Dr. Eben Alexander (chm.) Winston-Salem

Dr. Guy Odom, Durham

Dr. Rowland Bellows, Charlotte

General Surgery Dr. I. E. Harris (chm.), Durham Dr. Walter Kitchin, Clinton Dr. Wm. Hollister, Pinehurst Dr. Warner Wells, Chapel Hill

Plastic Surgery

Dr. Nicholas Georgiade, Durham Dr. Earle Peacock, Chapel Hill

10. Pediatrics

Dr. George A. Watson (chm.), Durham Dr. Charles R. Bugg, Raleigh Dr. Dan P. Boyette, Ahoskie

Anesthesia 11.

Dr. Howard Ausherman, Charlotte Dr. Charles Stephen, Durham

Neuro-Psychiatry 12.

Dr. J. Douglas McRee, Raleigh Dr. Hans Lowenbach, Durham

Pathology and Laboratory 13. Dr. June Gunter (chm.), Durham Dr. Kenneth Brinkhous, Chapel Hill

REPORT OF THE AD HOC COMMITTEE FOR STUDY OF TEXTBOOKS

The Ad Hoc Committee of the North Carolina State Medical Society has reason to believe that certain textbooks used in our public schools contain radical and objectionable doctrine foreign to the American Way of thinking.

The Committee is in accord with "the bill

of grievances" of the Sons of the American Revolution—this having been used in 1949 to petition Congress of the United States for Congressional Investigation of School Text books. This Committee is in accord with the speech of Hon. B. Carroll Reece—"America's Crisis in Education" made in the House of Representatives in 1958.

The Committee is in accord with the textbook study of the Daughters of the American Revolution wherein they made a list of satisfactory textbooks and unsatisfactory text-

books.

The following are the things the Committee does not like about the Sociology textbooks:

(1)"Propaganda line undermining respect for the Constitution of the United States"

"Students are led to assume that they have the right to be supported by the Government and that socialism affords the only solution to our economic problems"

(3) "Insignate that our people are not getting a square deal; create impression that reform is possible only by establishing a new social order'

(4) "Directly advocate socialized medicine as the answer to the people for satisfactory medical care.

This Committee has learned that:

(1) The National Education Association has acquired a virtual monopoly over courses of study and educational programs in the public schools. It has a commission which attempts to de-"educational policy" and termine force its views on local school boards.

(2) Article III, Section 2 of the National By-Laws of the Parent Teachers Association provides that "Local units . . . shall not seek to direct the Administrative activities of the schools or to control their policies." Members of local P.T.A. units are not allowed protest about textbooks methods of instruction - such matters being "out of order" under the by-law provisions.

(3) Letters from the textbook Commission of N. C. indicate that it is impossible for the Commission to read the textbooks because of tremendous volume of reading material. Thus, we are led to believe that the books are pipe lined from author to teacher with no in between evaluation or control.

The Ad Hoc Committee, working under

jurisdiction of the Ladies Auxiliary Committee has:

 Met with Auxiliary Committee and then sent background material to the ladies auxiliary groups in each county medical society.

 effected a state press textbook study committee and met with this Com-

mittee

(3) effected resolutions by the local chapters of the Daughters of the American Revolution, The American Legion, Ladies Auxiliary of the Veteran's of Foreign Wars. (Kinston)

(4) Met with the local lawyers in Kinston and have reason to believe this will be presented at the State Bar Asso-

ciation Meeting.

The Ad Hoc Committee recommends that pressure be brought to bear — locally and at a State level — to effect the substitution of a good course in American History for the present course in sociology in the high schools of North Carolina.

S Joseph S. Bowers, M. D. Chairman, Ad Hoc Committee Members of Committee Dr. Jack Peele Dr. Lynwood Williams Dr. Eugene Keiter

REPORT OF COMMISSION ON THE ANNUAL CONVENTION

Your Commissioner has the privilege of reporting the following deliberations, conclusions, and recommendations of the 6 committees comprising the Commission on the

Annual Convention.

(1) THE COMMITTEE ON ARRANGE-MENT OF FACILITIES FOR THE ANNUAL SESSION, of which Dr. John Rhodes is Chairman, met in Chapel Hill, September 24, 1958, to formulate plans for the 105th Annual Convention. The Committee considered comprehensive agenda, discussing in detail certain items concerned with changes in the program, with particular reference to elimination of the night meeting of the House of Delegates and rescheduling the poorly attended Third General Session.

In accord with suggestions from President Baker, the Committee recommended a called meeting of the House of Delegates to be convened at 9:00 A. M., Monday, May 4, and to be reconvened Monday afternoon, after lunch, to conclude the business of the First Session. The Committee recommended that the Second Session of the House of Delegates be moved from Wednesday afternoon to Tuesday afternoon and that the Third General

Session be convened on Wednesday, immediately following adjournment of the Second General Session instead of at 5:00 P. M. on Wednesday. It was suggested that the awarding of exhibitors prizes follow the Third General Session. These changes have been incorporated in the official program.

Investigation and discussion of locations for the 1960 meeting led to the conclusion that at present Asheville and Raleigh are the only locations with suitable facilities.

(2) THE COMMITTEE ON CREDENTIALS OF THE DELEGATES TO THE HOUSE OF DELEGATES, of which Dr. Milton Clark is Chairman, reports that all of the Delegates at the 1958 meeting were properly certified.

(3) THE COMMITTEE ON AUDIOVISUAL SCIENTIFIC POSTGRADUATE INSTRUCTION, of which Dr. Leonard Goldner is Chairman, has arranged an Audiovisual Postgraduate Instructional Program for presentation on May 3 and May 4. In addition to subjects of general interest the presentation will include surgical problems, urological reconstruction, the physiology of gastric function, certain problems in cancer, safety in x-ray techniques, and respiratory acidosis.

No formal panel discussions were arranged because of the limited attendance at previous meetings. Members of the Audiovisual Committee are to act as discussors of the individual presentations, and the audience will be encouraged to participate. In addition, the Committee suggested that its Sunday program be emphasized by a special letter to the members of the Medical Society, that adequate signs be available outside of the Auditorium indicating where the meeting is to be held, that the Academy for General Practice be questioned as to what subjects it would like presented next year, and that the Academy also be urged to encourage its members to attend the Audiovisual Postgraduate Instructional Courses.

(4) THE COMMITTEE ON SCIENTIFIC EXHIBITS, of which Dr. Everett Bugg is Chairman, has assembled a total of 26 exhibits. Of these, 50 per cent (a considerably larger proportion than usual) are being pre-

sented by Members of the Society.

(5) THE COMMITTEE ON AWARDS AND SCIENTIFIC WORKS, of which Dr. Rowland Bellows is Chairman, reports that at the 1958 meeting of the Society, it carried out its usual function of appraising motion picture presentations, scientific exhibits, and other audiovisual media. Subsequently, it has been engaged in evaluating manuscripts presented at the 1958 meeting. Delay in re-

ceiving the last manuscript made it impossible for the Committee to complete its appraisal before March 1959. Such delay is unreasonable in view of the Society requirement that the essayist turn in his manuscript to the Section Secretary immediately following his presentation. It would seem reasonable that an absolute deadline be established and that any paper not submitted prior to such deadline be considered ineligible for appraisal by the Committee and for receiving an award.

(6) THE COMMITTEE ON THE MEDICAL GOLF TOURNAMENT, of which Dr. Walter Watts is Chairman, has made arrangements for the Men's Golf Tournament to be played at the Asheville Country Club on Monday, May 4 and Tuesday, May 5. Unfortunately, Sunday, May 3 was not available because of prior commitments. Appropriate prizes for this tournament have been ar-

ranged by the Headquarters Office.

With the Committee's approval, a local Arrangements Committee of the Women's Auxiliary has scheduled a Women's Golf Tournament to be played at the Biltmore Country Club on Monday, May 4. Suitable prizes for this tournament have been secured by the Headquarters Office. Any matters related to this tournament may be cleared with Mrs. John R. Hoskins, who represents the Auxiliary of the Buncombe County Medical Society.

/s/ R. B. Raney, M. D., Chairman Commission on Annual Convention

PUBLIC SERVICE COMMISSION REPORT Dr. John R. Kernodle, Chairman, reporting:

The Public Service Commission met in Raleigh on Sunday, March 15, 1959 at the request of John R. Kernodle, M. D., Chairman. The organization of the Commission was explained by the Chairman and individual reports were given by Committee Chairmen. These reports have been briefed in this combined report to be given to the Executive Council and to the House of Delegates at the annual May meeting. This report contains continuing programs of each Committee; new programs proposed for the coming year; and specific requests that require definite action and approval by either the Executive Council or the House of Delegates.

Anesthesia Study Committee: David A. Davis, M. D., Chairman

The Medical Society has had an Anesthesia Study Committee for the past five years and the Chairman stated he felt sufficient data had been collected to have a report made to all physicians and suggested an article to be

published in the North Carolina Medical Journal during 1959. Information on deaths attributed to anesthesia is obtained for the State Board of Health's Vital Statistics Division. For 1958, some 30 deaths were noted as being caused by anesthesia. mately 50% of these deaths were considered good to excellent risks before application of the anesthetic, whereas some few were not considered good risks at the beginning of the operation, 25% of the deaths were patients undergoing minor operations, such as T & A; hernia; appendectomy; or historectomy. Dr. David A. Davis reported that relative few deaths had been reported from spinal injections. It is the feeling of the Chairman and of his Committee that the person giving the anesthetic and not the anesthetic itself was the biggest factor in these deaths. One was that hospitals need to improve their concern as to the type suggestion made of employees they have giving anesthesia for the protection of the patients.

Recommendations

1. Continuation of the Study Committee

2. Cooperation of the State Medical Society in publicizing the findings of the five-year study.

Advisory Committee to the Board of Public Welfare of North Carolina: Dr. J. Street Brewer, Chairman

This Committee held three meetings during the year with Dr. Ellen Winston, Commission of Public Welfare, and members of her staff. Major consideration was given to the proposed legislative requests of this department of state. Both the A and B budgets submitted to the Advisory Budget Commission were reviewed and discussed in detail. The Committee agreed with the proposed budget in most details and certainly with the overall principles involved. Recommendation was made to the Executive Council that the Medical Society should support the budget of the State Board of Public Welfare when presented to the Legislature. These proposals included: (1) State General Assistance funds to match county funds; (2) Sterilization after the second or third illegitimate child considered; (3) Care of the aged and the purchase of skilled nursing service for aged patients; (4) Policies with reference to tuberculososis sanatoriums, drugs for indigent patients and the homemaker services of the welfare program.

Recommendation:

Request the Medical Society to continue its present relationship with the State Board of Public Welfare through its Advisory Committee. It is important for the Society as physicians to know what is going on in a

medical way in the Welfare Department. Likewise, it is worthwhile and a benefit to the State Board of Public Welfare to have the advice and the approval and sometime the criticism, of the Committee from the State Medical Society.

Committee on Cancer: James F. Marshall, M. D., Chairman

This Committee has worked closely with the Governor's Commission on Cancer Control and reviewed the 10 points of this Commission Study Report. Of these 10 points. the Committee on Cancer took action on five: (1) The amount of money appropriated by the Legislature for the diagnosis and treatment of indigent patients with cancer be increased and that counties be urged to match the State and Federal funds when applied to individual patients with cancer; (2) That the Cancer Committee adopt as one of its major programs, in conjunction with the Cancer Society and the State Board of Health, the taking of Papanicolaou smears by all physicians doing complete and or pelvic examinations on women. In addition, that the Legislature be urged to appropriate funds for training cyto-technicians in order that there be sufficient personnel to carry out the program; (3) That the North Carolina Cancer Institute remain at Lumberton and that the physicians treating those patients be commended for their unstinting and unselfish work; (4) That the pathologists in the state be requested to report cancer cases to the State Board of Health, as required by law. so that these statistics will more nearly approach the actual number of cases in North Carolina and some conclusions can thereby be drawn as to the number of cases present and at some future date, one can determine whether or not progress is being made in the cure of cancer in this state; (5) That additional State funds be appropriated for cancer research facilities at the North Carolina Memorial Hospital at Chapel Hill.

Recommendation:

That the existence of the Commission for the Study and Control of Cancer be continued for the effective use of assembled information and to study means of implementing the recommendations made in the 1958 report and to assist in their development.

Committee on Child Health: Angus M. McBryde, M. D., Chairman

This study began in 1956 with the Medical Society and the State Board of Health jointly participating financially. It is strictly a voluntary program on the part of the hospitals and clinics. At first, only hospitals having as many as 500 deliveries were studied as to neonatal deaths, but later this was changed

to hospitals having as many as 100 deliveries per year participating. To date, after three years, a total of 3500 neonatal deaths have been studied by this sub-committee.

Recommendations:

(1) Continuation of the study committee with the same budget from both sponsors, Medical Society and the State Board of Health: (2) A summary report prepared for publication in the State Medical Society Journal; (3) Report of this study to the AMA Child Health Committee for additional publicity. (Information only: The Committee is proposing a standard report form for hospitals to obtain pertinent data regarding history of pregnancy, delivery, and conditions apparent during neonatal life.)

Committee on Chroni Illness: John R. Kernodle, M. D., Chairman

The State Chairman and other Medical Society officials have represented the Committee and the Medical Society at several National, Regional, and State meetings in the interest of the health care of the Chronically Ill and Aged. Through the State Committee plans are being made to: (1) Form Joint Committee for the Health Care of the Chronically Ill and Aging on the state level; (2) Promote local action programs through county medical society chronic illness chairmen. (To date, we have 43 chairmen named representing 52 counties.); (3) Co-sponsor a Southeastern Regional Conference on Aging of the National Assembly of Social Welfare in 1960;; (4) Participate in the planning for the Joint Council's Conference on Aging to be held in Washington, D. C., June 14-16, 1959; (5) Participate on the National level for the 1961 White House of Conference on Aging; (6) Cooperate and assist in the planning and organization of the North Carolina State Conference on Aging for 1960 in cooperation with the Governor's Commission on Aging; (7) Participate in the planning for a special workshop on Aging being sponsored by the North Carolina Conference for Social Service. (1959); (8) Support legislative requests of the State Board of Public Welfare and Medical Care Commission to the 1959 General Assembly; (9) Cooperate with the Insurance Council to study and prepare some recommendations for broadening the base and specific coverage to older persons; (10) Support demonstration programs of Public Health in Person County; Homemakers program in three rural counties — Alamance. Chatham, and Harnett of Public Welfare.

Recommendations:

(1) Continuation of the Committee on Chronic Illness with increased emphasis given to the formation and organization of local society committees on chronic illness. Encourage representation of all agencies and organizations engaged in either a service or educational program for the health care of the chronically ill or aged; (2) Continue support given other agency service programs that will assist with home care programs; (3) Strengthen the cooperative efforts of the Joint Committee for the Health Care of the Chronically Ill and Aged; (4) Continue working with Insurance companies, both Service and Commercial, for expansion of policy coverage and benefits to persons over 65; (5) Encourage some action on insurance programs following the AMA proposal and the action of the Iowa State Medical Society as of February 22, 1959. Also encourage our Blue Shield Committee to continue their efforts for increased coverage in North Carolina; (6) Continue the liaison contacts of the Medical Society representatives with AMA, National, Regional, and State programs being planned and organized for the improved health care of these two segments of our population. Maintain the leadership role already established by the Medical Society in this area of health and medical service.

Committee on Maternal Health: James F. Donnelly, M. D., Chairman

The Chairman reported on the activities of this Committee and stated they were beginning their evaluation study of the third—one thousand maternal deaths since their beginning of the study in 1946. The committee this year completed its second one thousand death study as shown in the following table:

BIRTH RATE, LIVEBIRTHS, AND MATERNAL MORTALITY NORTH CAROLINA, 1949-1958

		1	Maternal	Mortal-
	Birth Rate	Livebirths	Deaths	ity Rate
1949	27.0	107,970	127	11.8
1950	26.2	106,486	126	11.8
1951	26.9	110,910	123	11.1
1952	26.7	111,272	113	10.2
1953	26.5	111,856	109	9.7
1954	26.9	114,846	91	7.9
1955	26.7	115,365	96	8.3
1956	26.5	115,792	78	6.7
1957*	25.6	113,143	81	7.2
1958*	24.9	111,280	60	5.4

*Provisional rates, Source: National Office of Vital Statistics, USPHS, Section on Vital Statistics, North Carolina State Board of Health.

During the past year the maternal deaths from the inception of the committee until the present time were analyzed and some of the pertinent data are herein presented.

PRIMARY CAUSE OF DEATH

	Gro	up #1	Gro	up #2	To	otal
Toxemia	264	26.4%	264	27.6%	528	27.0%
Hemorrhage	259	25.9%	226	23.6%	485	24.7%
Embolism	74	7.4%	87	9.1%	161	8.2%
Infection	73	7.3%	52	5.4%	125	6.4%
Cardiac	46	4.6%	25	2.6%	71	3.6%
Anesthesia	25	2.5%	28	2.9%	53	2.7%
Other Obstetric	103	10.3%	94	9.8%	197	10.0%
Nonobstetric	113	11.3%	148	15.5%	261	13.3%
Indeterminate	33	3.3%	35	3.6%	68	3.4%
Obstetric	844	84.4%	776	81.0%	1620	83.3%
Nonobstetric	113	11.3%	148	15.4%	261	13.3%
Indeterminate	33	3.3%	35	3.6%	68	3.3%

This table represents the primary cause of death and the cases received by the committee. In essence the two leading causes of maternal mortality remain the same in the designated periods. Toxemia continues to be the leading cause of maternal mortality with hemorrhage a close second. Infection continues to drop as a cause of maternal mortality, the number of cases in which information was inclusive remains at the level of $3\frac{1}{2}$ per cent. The examination of maternal deaths by race indicates that maternal deaths are concentrating in the non-white segment of the population.

RACE AND LEGITIMACY

White	41.5%	33.5%	37.0%
Nonwhite	58.5%	66.5%	63.0%
Legitimate	83.0%	85.0%	84.0%
Illegitimate	17.0%	15.0%	16.0%

Prenatal care in the women died in association with pregnancy still indicates that a very large percentage of them do not receive any prenatal care or such prenatal care is inadequate.

The preventable factors were numerous but it was a happy note that the percentage of preventable cases dropped from 90.9 per cent in the first 1000 to 86.9 per cent in the second thousand.

In examining the causes of maternal mortality in detail it is noted that although the relative proportion of toxemia increased, incidence of eclampsia dropped, the incidence of both pre-eclampsia and hypertensive cardiovascular disease did increase. In the maternal deaths due to hemorrhage an increase was noted in the number of ectopic deaths, deaths due to premature separation of the placenta, and to rupture of the uterus. The problem of rupture of the uterus is certainly a preventable one and appears to be an unnecessary increase. Reduction was noted in connection with placenta previa and in postpartum hemorrhage. The number of patients who died from hemorrhage and failed to receive any blood continues to be high, being approximately two-thirds of the entire group. Students of the problem of maternal mortality are in agreement that although the overall rates are dropping essentially the same problems exist. Furthermore, in spite of the rather marked improvement in maternal mortality, the other measure of maternity care, perinatal mortality, has not dropped at the same rate.

Dr. John C. Burwell, Jr., of Greensboro, who is Chairman of a Committee of the North Carolina Obstetrical and Gynecological Society to consider the problem of legalizing sterilization, outlined the purposes and functions of his committee. He stated that aside from the Eugenics Law there was no legal definition for sterilization, either for medical or non-medical reasons. A number of interested groups have been contacted concerning this matter. There was considerable discussion of the problem of legalizing sterilization for medical and social indications aside from those concerned with eugenics or the problem of illegitimacy. The Committee felt that control of sterilization by organized medicine including the component county medical societies, the Committee on Maternal Welfare and the North Carolina Obstetrical and Gynecological Society would be a preferable method of control to the ever possible threat of legal action against the physician performing such a procedure. No official proposal was made by Dr. Burwell in view of the fact the North Carolina Obstetrical and Gynecological Society has not yet had a report from his committee and therefore has taken no official action on it.

The Committee stated that any records would be made available in reference to the problem which Dr. Burwell's committee desired and would assist in the activities of the

committee in every way possible. Further action on the problem was deferred until an official report was made.

At the February 15, 1959 committee meeting, special guests included Dr. Nicholson J. Eastman, Professor of Obstetrics of Johns Hopkins University, Baltimore, Dr. Madeleine Morcy and Dr. Eleanor Hunt of the Children's Bureau, and Dr. Angus McBryde, Chairman of the Committee on Child Health. The primary purpose of this meeting was to discuss the effects of the predicted increase in the obstetric load within the next 10 to 15 years. Currently in the United States, there are slightly over four million deliveries a year. It is expected to reach six million by 1970. The predicted obstetric loan in the future for North Carolina, based on a survey, was prepared by Mr. C. R. Council, Chief of the Section on Vital Statistics of the State Board of Health, and is presented

ESTIMATED LIVE BIRTHS BY RACE: NORTH CAROLINA, 1960, 1970

Birth Rate Per 1,000 Population Race High Average Low (1950 - 1957)(1954)(1957)26.5Total 26.925.6 White 24.3 23.9 22.9 Nonwhite 34.434.0 33,4 Con't.

 Estimated Number Births

 High
 Average
 Low
 High
 Average
 Low

 122,785
 120,959
 116,851
 135,974
 133,952
 129,403

 39,749
 39,287
 38,594
 42,323
 41,831
 41,093

 82,839
 81,475
 78,066
 92,935
 91,405
 87,581

The summary of the number of deliveries according to the size of practice and the type of practice in North Carolina in 1958 is depicted in the following table.

DISTRIBUTION OF DELIVERIES BY SIZE AND TYPE OF PRACTICE Size of Practice Type of Practice

	0	1	6	5	2	3 & 4	7	8 & 9	Total
0-100	562	34,915	718	1796	1314	2428	908	570	43,211
	1.3		1.7	4.2	3.0	5.6	2.1	1.3	100.0
101-200		17,196	0	872	2814	6640	1324	136	30,124
~~	3.8		~		9.4	22.0	4.0	0.5	100.0
201-300	506			232	1708	55.74	942	0	14,138
C/E	3.7				12.1	39.4	6.7	0	100.0
301-plus		322	342	0	5098	2404	340	0	10,746
7	20.8				47.3	22.4	3.2		100.0
Total	4450	57,359	1310	29001	0,934	17,046	3514	706	98,219
67	5.0	58.4	1.3			17.3		0.7	100.0

Following the discussion, the committee as a group felt that better trained paramedical assistants certainly was part of the answer. It was further felt that better training in obstetrics, both for the general practitioner as well as the specialist was indicated and a

measure should be instituted to attract more people to this field.

Dr. Charles Pace, a member of the com mittee, offered the following written suggestions after this meeting:

1. Form a continuing body to consider

this problem if deemed beyond the province of the present committee.

Acquaint all of the county societies

with this question.

Start in the hospitals throughout the state the program of training obstetric asssitants.

Take steps to correct the general short

age of nurses.

This will be the subject of further discussion on the part of the Committee with the hope of providing recommendations of a specific nature to meet these anticipated needs.

The Committee on Maternal Health held

two meetings during the year.

With reference to prenatal clinics, Dr. Don nelly expressed his own personal feeling that the best way to handle prenatal clinics is as out-patient clinics at the local hospital. At present, most of these are held at the local health department with local physicians manning the clinics. The biggest draw back to having the clinics at the hospital is the financing of the extra personnel - clerk, nurse, etc., for which there are no Federal funds available to meet this cost of operation. It was also stated that North Carolina ranks in the upper 7 states in effectiveness and quality of work done by its Committee on Maternal Health.

Recommendations:

1. Continuation of present budget for conducting the third-one thousand maternal death study.

2. Continued emphasis given by physicians and health departments for improved prenatal care.

Mental Health Committee:

Dr. Allyn B. Choate, Chairman

Two committee meetings held during the year. Major consideration given to: (1) Legislative request for a revision of North Carolina General Statute 14 - 177 Bill regarding Crime Against Nature and Sex Deviates; (2) Cooperation with the promotion of Mental Health Clinics for North Carolina; and recommendations as to the use of Hypnosis in the practice of medicine.

The Crime Against Nature Bill was not considered a Bill that the Medical Society should promote alone, but expressed interest in seeing that some other group sponsor the Bill, such as a law enforcement agency and the Medical Society would support it.

Close liaison contact is maintained between the Medical Society's Committee on Mental Health and the Public Health Mental Health Clinics and the North Carolina State Board of Hospital Control through committee membership.

Recommendation as to the use of Hypnosis The State Committee recommends that the State Medical Society take the same stand on this practice as did the AMA in June 1958. "Approve the practice of hypnosis for general practitioners, medical specialties, and dentists—as a therapeutis adjunct within the specific field of their professional competence. Teaching related to hypnosis should be under responsible medical or dental direction, and integrated teaching programs should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be discouraged.'

Recommendations:

The committee recommends increased opportunities for psychiatric training for general practitioners in seminar and postgraduate courses throughout the state.

Continued support to the establish-

ment of Mental Health Clinics.

Committee on Occupational Health: Dr. Harry L. Johnson, Chairman

The third annual Governor's conference on Occupational Health was held at Chapel Hill, February 5, 1959, and the sixth annual Occupational Health Seminar was held the following day. The Committee met at the close of the Governor's Conference to discuss basic plans for the 20th annual AMA Congress on Industrial Health. The Governor's Council and the Charlotte Council will assist in sponsoring the Congress when it meets in Charlotte in 1960. The program is incomplete but will be tailored to benefit the small industry and the general practitioner in his role as small plant physician.

Recommendations:

Medical Society to support and cooperate with the AMA Congress in planning and promoting the 1960 annual Congress meeting to be held in Charlotte.

2. Cooperation of the Public Relations Committee in assisting with publicity for

this meeting.

3. Full cooperation given the National Congress group by the Medical Society's Committee on Occupational Health.

Committee on Poliomyelitis: Dr. Samuel F. Ravenel, Chairman

Through the efforts of this Committee, the Medical Society, its Legislative Committee, sponsored a compulsory polio vaccination bill for children between 2 months and six years of age. This Bill passed both the House and Senate of the 1959 General Assembly. Because of the excellent educational program of the Society's Committee on Polio, this Bill had little or no opposition in passing.

Committee on Veterans Affairs:

Dr. Samuel L. Elfmon, Chairman

This Committee held three meetings during the year and is concerned at the present over some proposed changes in the Medical Care of Service Connected Veterans. Since 1946, North Carolina has had an intermediary home-care program, being one of nine states to have such a program. Hospital Saving Association serving as intermediary between the physicians of North Carolina and the Veteran's Administration handles all claims and payments for service caused illnesses treated by family physicians. At the end of 1958, we had 2075 participating physicians (375 have been approved for specialty rating); 1087 received payments during the fiscal year ending June 30, 1958. Since 1950 the V. A. has attempted in many ways to eliminate the intermediary on the basis of economy. The Committee feels that the Medical Society needs the service of a well organized business organization to represent the physician in his transactions between the service connected veteran and the

In February 1959 following a meeting in Chicago the AMA Committee on Federal Medical Services agreed to make a strong endorsement of the Home-Town Care Program, with a particular recommendation of the merits of the intermediary system, based on the convictions that this is the best means of caring for the service-connected veteran, providing continuity of care by a physician chosen by the veteran himself. The AMA Council on Medical Service has approved this stand and an educational program will be carried out through State Associations in an attempt to arouse their enthusiasm and interest in the program.

The new contract proposed by the V. A. would remove the authority for the intermediary to review V. A. records, physicians requests for treatment, to audit the physician's bills and the employment of a person to visit physicians in order to help them resolve problems with the V. A. The Committee in North Carolina has rejected this new contract. The Committee also proposed to the V. A. Central Office and the AMA that the Home Town Program be extended for service-connected veterans beyond the treatment given the veteran in his home or in the office of his home-town physician, but to try experimentally in a limited way, treatment in Home Town Hospitals limited to service-connected illness. This program could be tried and limited to a specified illness and/or to specific geographical location. It would solve the problem of ever increasing V. A. hospital

beds.

Recommended Action:

1. The Committee on Veteran's Affairs has rejected the proposed contract offered by the V. A. and requests support and recommendation by the Executive Council in May 1959 as to not accepting the new contract but to maintain the Hospital Saving Association's intermediary program. An answer must be given the V. A. before June 30, 1959.

2. Request for this Committee to be changed to the Commission on Insurance and not Public Service Commission.

Committee on School Health:

Dr. Charles H. Gay, Chairman

The Chairman reported on a joint meeting held in Raleigh of the Medical Society, Dental Society, and the State Board of Health in January 1959. The purpose of this meeting was to discuss the utilization of the School Health Funds designated for correction of remedial defects among school age children. This was the only meeting of this Committee held during the year.

Recommendations:

- 1. The Committee congratulates the work being done in Buncombe County through the local School Health Council.
- 2. Recommends that each component medical society appoint a chairman and subcommittee on school health to promote better relationships and understanding between physicians, dentists, educational leaders, public health, public welfare and the parents of school age children. Such committees were approved for county medical societies in 1957.
- 3. Some representation of the Medical Society's Committee on School Health to attend and participate in the Seventh National Conference on Physicians and Schools to be held in October 1959 and sponsored by the AMA.

4. Continued medical leadership and guidance in all phases of the school health program in North Carolina.

All committees and the commission should formulate a budget as first order of business and report to Headquarters by July 25th.

's ' Dr. John R. Kernodle, Chairman

THE PROFESSIONAL SERVICE COMMISSION REPORT

Dr. George W. Paschal, Jr., Commissioner

The Commissioner of the Professional Service Commission submits the following resume of the six committees in this group: I. Committee on Emergency Medical Service and Military Affairs: Dr. George W. Paschal, Jr., Chairman

- This committee formally met on March 1, 1959, in Raleigh, N. C. The meeting was attended by the Executive Secretary, Mr. James T. Barnes, and a representative from the North Carolina Office of Civil Defense. With the committee's approval opposition to the draft of physicians who are to be directed to perform services in government facilities which services could be performed in civilian facilities by civilian physicians was made to the North Carolina Delegation in Congress and Congressional Committees on Military Affairs. The Committee strongly felt that the obligations of physicians under the draft does not extend to government programs which are not primarily organized for the care of military personnel but rather to care for civilian personnel and the dependents of Armed Forces personnel. Representation was made to the appropriate parties in Congress that the incentive pay for medical personnel be continued as is currently in effect.
- The chief item for consideration was related to the plan for capable medical care services in the overall Civil Defense Plan for North Carolina. A master plan providing for Emergency Medical Service was presented to the House of Delegates at the 1958 Meeting which was adopted by that body and therefore is sufficiently authorized. Written plans have been completed and filed with the State Director of Civil Defense for nineteen different counties. The committee recognized that in the event of an emergency of state-wide proportion that great coordination with authority at state and local levels would be required. The State Office of Civil Defense has no current power, but it is understood that North Carolina law provides that the Governor could assume unusual powers in case of an emergency. There is not an authority at the present time to integrate local and state plans. The Committee recommended:
 - 1. That each county hasten to formulate a plan.

2. That it conform in general with the plan written at the state level and with the plans and procedures of the State Office of Civil Defense.

3. To determine the number of county Medical Societies that have a plan and get an actual copy of these plans in the hands of the Medical Director under the state plan. (This means that a copy should be sent to Dr. George W. Paschal, Jr., Raleigh, North Carolina.)

4. Secure documentation of the disaster plan sand a roster of personnel which have been developed by the general medical-surgical hospitals in the state who conform to the standards of the Joint Council on Hospital Accreditation.

5. That the Counties adopt the disaster plans developed by the general medical-surgical hospitals in the community and place these on operational basis and integrate these plans with the Office of Civil Defense plans at the county society level.

6. To bring up-to-date the roster of the personnel participating in these disaster plans as developed by the general medical-surgical hospital.

- C. The committee approved a plan of demonstrating a 200 bed hospital unit during this meeting which is available from the Office of Civil Defense. It was suggested that it be demonstrated a different locations over the state and that the medical personnel needed for the satisfactory operation of such a unit familiarize themselves with the equipment so that, if necessary, this unit could be put into actual operation.
- D. The committee felt that personnel of the three medical schools—both students and faculty—should be utilized but had no specific recommendation pending further study.
- E. All county societies are urged to complete their planning for Emergency Medical Service as quickly as possible.
- II. Committee on Eye Care and Eye Bank: Dr. H. M. Dalton, Chairman
 - A. This committee had no formal meeting during the year, but ap-

proved a glaucoma detection program among industrial workers. Pamphlets entitled "What is an Ophthalmologist" were distributed to members of the legislature. No call from the Eye Bank was received during the year.

- III. Committee on Insurances: Dr. Joseph W. Hooper, Chairman
 - A. This committee has had several conferences during the year. One with the underwriter of our State Medical Society approved program yielded results in that a 10% reduction of the current premiums was accomplished. Further reduction is possible if experience continues favorable.
 - B. At a conference with Mr. J. L. Crumpton, the Administrator of the disability program endorsed by the State Medical Society, the committee gave approval for Mr. Crumpton to put forward a proposal of a plan his company wishes to offer the State Medical Society with broader benefits.
 - C. Following a conference with Mr. Golden of Durham who discussed the group professional overhead expense program as well as the catastrophic hospitalization program, both of which are sponsored by the Medical Society of North Carolina, the committee cooperated in efforts of Mr. Golden and his company to secure greater participation of our members in the program.
 - D. The committee considered the problem of group life insurance for our membership but has no recommendation at this time.
 - E. The committee recommends that the Medical Society should take an active part in acquainting the general public as to what should be expected from health insurance.
- IV. Committee on Necrology: Dr. Charles H. Pugh, Chairman
 - A. The Committee on Necrology performed its usual duties in that they have stimulated activity in listing all physicians who have died during the past year. They have filed appropriate information at State Headquarters. Deaths for 1957-1958 have been published in the Roster with solemn designation. Listing of 1958-1959 deaths have

been made in the Official Annual Sessions program.

B. The usual Memorial Service was arranged and conducted.

- V. Physicians Committee on Nursing: Dr. H. L. Brockmann, Chairman
 - A. This committee has had regularly well attended meetings. The committee desires to keep the profession informed regarding nursing.
 - B. Nationally, there is consideration of combining the American Nurse Association and the National League for Nursing. Opinion is divided as to its advisability.
 - C. The American Hospital Association appealed to the National League for Nursing to convert its Board of Accrediation of Nursing Schools into a joint board with representatives from the American Medical Association, American Hospital Association, American Nurse Association, and National League for Nursing. Up to the present the National League for Nursing considers accreditation the function of nurses only.
 - D. Recently there has been an increase in the percentage of failures on nurses state board examinations for licensure in the United States. We, in North Carolina, sent a resolution to the Trustees of the American Medical Association asking for medical representation on the Blueprint Committee which selects the questions for the state board examinations. Action on this has been deferred for reconsideration by the A.M.A.

E. Legislation at the national level is being proposed for federal grants and scholarships for collegiate education in the field of nursing. This committee opposes this action.

F. For North Carolina, representatives of this committee served on the North Carolina Committee on Nursing and Nursing Education and the North Carolina Commission on Patient Care. This Committee in conjunction with the Commission on Patient Care recommends the establishment of local committees in each hospital in North Carolina to improve patient care. It recommends publicizing activities in the nursing field. It has endorsed current legislation asking for scholarships for nurs-

ing students on the basis of financial need and students who are physically, intellectually and morally qualified. It also supports a portion of the bill which asks for direct financial aid by the state for nursing schools. The committee urges the support of the membership of the Society in promoting this legislation.

VI. Committee on Postgraduate Medical Study: Dr. Joseph B. Stevens, Chairman

A. This committee has cooperated and encouraged participation at both state and local levels in the dissemination of information concerning Staphylococci infection and its control.

B. The U. N. C. Postgraduate Extension Courses are still fairly popular. The demand is holding up at a level just above the self-supporting

level.

The Chairman reviewed correspon-C. dence from the National Foundation announcing 16-million dollars in scholarships to be awarded throughout the nation and allocated to the states on basis of population. North Carolina will get fifteen of the scholarships annually, three each in the following professional categories: health Medicine, Medical Social Work, Nursing, Physical Therapy, Occupational Therapy. These scholarships will be for \$500 a year for four years or a total of \$2,000 providing the recipient maintains the prescribed scholastic standards. Information concerning channels of application may be secured from our Executive Secretary.

D. The committee recommended that the Public Relations Bulletin continue the practice of enclosing a listing of Postgraduate opportunities in North Carolina periodically. It was also suggested that a reference in the Bulletin should be made to the special issue of the Journal of the A.M.A. which lists twice a year Postgraduate oppor-

tunities for the nation.

E. The subject of television clinics for members of the Society to be broadcast from some of our Medical Schools was discussed but action was deferred pending further investigation.

George W. Paschal, Jr., M.D.

Commissioner.

PUBLIC RELATIONS COMMISSION REPORT

Dr. Edgar T. Beddingfield, Jr., Chairman The Commissioner of The Public Relations Commission has attended meetings of all the Committees in this group with one exception. The Committee Chairmen have all been most cooperative in informing me regularly of their activities and in providing copies of correspondence.

Summary of Committee Activities:

Committee on Hospital and Professional Relations and Liaison to North Carolina Hospital Association. Dr. Theodore Mees, Chairman: This committee has had its attention called to several controversial situations over the state involving relations between hospital professional staffs and Boards of Trustees. It is to the credit of this Committee that all these disputes have apparently been amicably resolved. In each instance, the Committee carried on a most thorough investigation and made objective findings and suggestions. The Committee is presently conducting a questionnaire survey to gather information on methods of determining medical indigency in regard to professional fees. In spite of the fact that a duly scheduled meeting was called and held for liaison with the North Carolina Hospital Association, no representatives of the Hospital Association were present.

Recommendations:

(a) That the work of the Committee in the field of Hospital and Professional Relations be continued at the present high plane.

(b) That the survey on medical indigency

be completed.

(c) That in the 1959-60 Society year, another Liaison meeting with the North Carolina Hospital Association be scheduled with a reminder letter going from the president of the Medical Society to the president of the

hospital group.

2. Committee on Legislation: Dr. Hubert Poteat, Chairman: This Committee held one formal meeting in November, 1958, some two months prior to the convening of the General Assembly. At this meeting, the Committee agreed to have introduced and to actively support a bill for compulsory polio vaccination. The success of this legislation is now a matter of record. The Committee voted to lend its support to certain legislation developed and devised by the Highway Patrol relative to chemical tests for alcohol in persons suspected of drunk driving. Those at the Committee meeting and since the Committee meeting many other matters of lesser direct importance to the Medical Society have come to the attention of the Committee on Legislation and considerable time and effort have

been spent by the Committee in personal contact and by direct telephone and mail communications with our representatives in the legislature. It was the opinion of the committee chairman that there was no need to call another full scale meeting of the Committee on Legislation inasmuch as close liaison had been maintained with all interested parties and the Commissioner concurs in this opinion. It is apparent that in some future legislative sessions bills might be introduced in which the Medical Society would have more at stake than has been true un until this point in the present legislative session and in such an eventuality periodic meetings of the Committee on Legislations would have to be held.

Recommendations: None.

The work of this Committee should be continued at the present high plane. It has functioned well as presently organized during the past Society year.

3. Committee on Medical-Legal: Dr. Ben-

nett B. Poole, Chairman:

This Committee met twice during the year. Members of the Committee attended and participated in a meeting sponsored by the North Carolina Bar Association at which an institute on "The Medical Aspects of Personal Injury Litigation" was held. Through the efforts of the Committee, participation in the Medical-Legal Interprofessional Code has increased throughout the state as evidenced by an increased demand for copies of the Code. Changes have been made in the State Interprofessional Code to bring it into conformity with the recently adopted National Interprofessional Code. Many joint meetings at the County level between representatives of the two professions have been held throughout the state during the year.

Recommendations:

(a) That the work of the Committee be commended and continued.

(b) That County Societies be urged to make more use of the facilities of this committee so that at least one Medical-Legal meeting is held in each County Society each year.

4. Committee on Public Relations: Dr. Edgar T. Beddingfield, Jr., Chairman:

This Committee has held two full scale meetings during the year. In addition to the continuing activities of this Committee in the areas which have, become traditional such as the exhibit at the North Carolina State Fair, the sponsoring of radio and television material, the complimentary subscriptions of "Today's Health" to various governmental officials, the support of the Science Fair Program, the widespread distri-

bution of educational mailing materials from the state office, etc., an innovation in committee activities this year was held in the form of a Conference of County Medical Society officers which was held in Pinehurst on January 10, 1959. Considerable favorable comment regarding this Conference was received from many of the attendants. Another innovation was the sponsoring of a sixteen week series of thirty minute television programs over the WUNC-TV, Channel 4. This series of programs covered a wide variety of health topics with participation by many Society members.

Recommendations:

(a) That the work of the Committe be continued and intensified.

(b) That the Conference of County Society Officers be held again during the coming year.

(c) That new attempts be made to explore the utilization of television as a means of medical public relations.

5. Committee on Rural Health and General Practitioner Award: Dr. Hugh A. Mat-

thews, Chairman:

This has continued to be one of our more active committees. The Committee this year has continued and improved many of their continuing projects such as cooperation with and sponsorship of the 4-H Health Improvement Program, the sponsorship of District Conferences on Rural Health, activities in the physician placement field, particularly in rural areas, working through existing community organizations and club programs to strengthen and direct their health activities, and the distribution of educational pamphlets to appropriate outlets. A departure this year was the sponsorship of a State Community Health Workshop in lieu of the annual State Rural Health Conference. Attendance at this workshop was by invitation alone and of some 200 invitations mailed, 161 persons attended the meeting. Most of the objectives of this intensive two-day workshop were attained.

Recommendations:

(a) That the work of this Committee be continued on the present high plane.

(b) That some thought be given to the sponsorship of County rather than District Rural Health Conferences. This suggestion is made because of the observation that most of the attendance at District meetings is generally from the County in which the District meeting is held. The difficulty in arousing County Society officers to opportunities for service in the field of rural health might be overcome by having more frequent meetings at a more local level, i.e., county level.

6. Committee on Liaison to the Insurance Industry: Dr. Frank W. Jones, Chairman:

At the direction of the President and the Executive Council of the State Medical Society the Commissioner was authorized to form such a Committee to function as an "ad hoc" committee during the 1958-1959 Society year. This organization was carried out and an initial meeting was held in Greensboro with representatives of the Health Insurance Council and its North Carolina component committee in January 1959. At this initial meeting committee organization was set up with co-chairman elected from the medical and from the insurance groups, an agenda of items of mutual interest was prepared and many of these were explored, and a decision was made regarding further meetings. A second meeting of the Committee was held in Raleigh in April. Examples of the areas of mutual concern which need to be discussed by such a group are as follows:

1. Utilization of standard insur-

ance claim forms

Promotion of the sale of voluntary health insurance as a continuing fight against the threat of social legislation

 Availability of health and accident insurance to older citizens, school insurance, fee

schedules, etc.

Inasmuch as the work of this Committee up until this point has largely been exploratory, no formal committee report is being made for this year.

Recommendations:

That the "ad hoc" committee has now gained enough experience in its appointed duties to be able to make recommendations to the governing body of the Medical Society of the State of North Carolina, and inasmuch as the Committee, by unanimous vote, has requested that they be removed from the "ad hoc" status and be made a Standing Committee within the framework of the Society, it is my recommendation as Commissioner that this Committee be made a Standing Committee and in my opinion it should be placed under the advisory and study commission along with the Committee on Blue Shield and the Committee to work with the Industrial Commission of North Carolina. This recommendation is made inasmuch as there seems to be areas of mutual interest between these committees that deal with various phases of health insurance.

Edgar T. Beddingfield

COMMITTEE ON AMERICAN MEDICAL EDUCATION FOUNDATION

Your committee held one meeting during

1958. One member was not able to attend because of an emergency, over which he had no control. Dr. Shuford, Chairman of the Advisory and Study Commission, attended our meeting which was held at Chapel Hill September 19th.

It was the concensus of the committee, Dr. Shuford, concurring that solicitation for funds for medical education be continued by mail as it has been for the past four years. Several mailings were sent out from American Medical Education Foundation headquarters in Chicago. A personal appeal to all of our readers was mailed out of our State Headquarters Office early in December. Contributions to A.M.E.F. or to the school of choice were solicited.

For the wonderful cooperation of Mr. Barnes, Mr. Hilliard, and the staff at the home office in Raleigh, we say thank you.

In 1957, 156 N. C. doctors contributed to A.M.E.F. \$5,690.00. In 1958, 138 N. C. doctors contributed to A.M.E.F. \$4,255.00. In 1958, 42 County Auxiliaries to our Medical Societies contributed to A.M.E.F. \$1,083.89. It will be noted that the Auxiliaries contributed approximately ½ as much as our doctor members. Congratulations and a big thank you to the ladies of the Auxiliary, Their goal for next year is a contribution from every member.

In 1957 our three North Carolina Medical Schools received in grants from A.M.E.F. \$21,882.00. The exact amount of grants from A.M.E.F. to our three N. C. Schools for 1958 is not available at this time, but was

comparable to those for 1957.

It is not the intention of your committee to recommend a dues increase though eleven states have done so. It is felt that the need for additional funds for medical education is of such import that the matter should be given serious consideration in the not too distant future.

- Recognition of the financial needs of our medical schools and of each physician's obligation to meet this need is a proper concern of organized medicine, and one in which a State Medical Society may justly enter with its collective approach and effort.
- All voluntary programs, however successful, fall far short of the suggess achieved by the various dues increase programs.
- The dues increase programs, in addition to producing substantial increases in contributions to A.M.E.F. have actually encouraged and produced an increase in the voluntary contributions to our medical schools.
- 4. There has been no significant loss of

membership as a result of the adoption of the dues increase program, and in the large state of Illinois not a single membership was lost.

In 1957, 9266 Illinois doctors gave A.M.E.F. \$199,257.00. And the same year Illinois Doctors gave medical schools, on a voluntary

basis \$172,391.00.

In 1957, 835 Arizona doctors gave A.M.E.F. \$9,113.00. And the same year Arizona doctors gave medical schools, on a voluntary basis. \$8,785.00. Evidently a considerable amount of money from doctors in other states is being allocated to our N. C. Schools. The over all amount received is inadequate.

s' H. L. Johnson, M.D., Chairman Wm. Petteway Pette, M.D. Manson Meads, M.D. Wm. Leroy Fleming, M.D.

COMMITTEE ON ANESTHESIA STUDY COMMISSION

This the fifth annual report made by the Chairman of this Commission. Except for a few alterations in figures, this fifth report might well be a carbon copy of the first. Preventable deaths due to Anesthesia are still occurring in the State of North Carolina.

During 1958 there were twenty-four deaths clearly due to anesthesia. In another three anesthesia was a definite contributing factor. In three other cases death followed the induction of anesthesia in extremely ill patients and although anesthesia might have been the immediate cause of death, the survival of these patients was very questionable. These might be considered anesthetic

deaths "without prejudice."

But in the twenty-seven cases which furnish the basis for this report, one finds that these were not moribund patients. Eighteen (66%) were rated "excellent" or "good" risks. Nineteen deaths occurred during elective surgery. These deaths, with two exceptions, occurred in connection with very common surgical procedures done almost every day in every hospital in North Carolina. Appendectomies, hysterectomies, tonsillectomies, herniorrhaphies, and deliveries contributed very significantly. As a matter of fact, ten (37%) deaths were incurred during operations usually classed as "minor." should serve to emphasize the concept that although there are "minor operations" there are few "minor anesthetics." As for anesthetic agents, one finds little of significance. The common agents such as pentothal, ether, nitrous oxide and cyclopropane find almost equal representation. Spinal anesthesia continues to be conspicuous by its infrequency

(1 death in this series, this supplemented by nitrous oxide-pentothal) but this case may represent the hazard of its use in connection with the spinal anesthesia.

Probably the most striking finding in this series is the frequency of death near the end of an operation or shortly after its completion. Eleven (40%) of the twenty-seven deaths fall in this category and more complete information might have revealed more cases in this category. This fact deserves further consideration, especially in view of the increasing pressure under which many anesthetists and operating rooms are working. At this point it is impossible to do more than speculate on this subject, but it does point out the need for constant vigilance of the unconscious patient. As in the past, available evidence points toward inadequate ventilation of the surgical patient.

This report is the last one submitted by the present Chairman. It has not been easy to sit in judgment of fellow physicians, especially when one sees many cases from his own institution pass in review before him. Now that this task will pass into other hands, this Chairman wishes to make a plea to the Medical Society of North Carolina, to all physicians, nurses and others who give anesthetics to patients: this is a serious situation which demands correction—please recognize this fact before the public and

their legal advisors do.

/s/ David A. Davis, M.D., Chairman John R. Ashe, Jr., M.D. Horace M. Baker, Jr., M.D. Duncan G. Calder, Jr., M.D. Samuel R. Cozart, M.D. D. LeRoy Crandell, M.D. Joseph S. Hiatt, Jr., M.D. Frank S. Parrott, M.D. Will Camp Sealy, M.D. Thomas B. Wilson, M.D. Charles R. Stephen, M.D.

COMMITTEE ON ARRANGEMENTS FOR ANNUAL SESSIONS

In accordance with the action of the Nominating Committee affirmed by the House of Delegates at the 1958 Annual Convention, the Committee on Arrangements met in Chapel Hill September 24, 1958 to formulate plans for the One Hundred Fifth Annual Convention to be held in Asheville May 2-6, 1959. The meeting was attended by Dr. John C. Reece, Dr. R. Beverly Raney, Dr. Joshua F. B. Camblos, Dr. Millard-D, Hill, Dr. Theodore S. Raiford, Dr. John S. Rhodes, Mr. James T. Barnes and Mr. William N. Hilliard. President Lenox D. Baker was unable to attend due to another engagement.

The Committee considered a comprehensive agenda, discussing in detail items concerned with changes in the program with particular reference to the elimination of the night meeting of the House of Delegates and a change of time for the always poorly

attended Third General Session.

In accord with suggestions from President Baker, the Committee recommended a called meeting of the House of Delegates to be convened at 9:00 A. M. Monday, May 4th, recess for lunch and re-convene Monday afternoon to conclude the business of the First Session. The Second Session of the House of Delegates would be moved from Wednesday afternoon to Tuesday afternoon.

The Committee recommended that the Third General Session be convened on Wednesday immediately following adjournment of the Second General Session instead of 5:00 P. M. on Wednesday. The awarding of Exhibitors' prizes would follow the Third

General Session.

These changes have been incorporated in the official program. President Baker has spared no effort to facilitate the business, scientific and social functions of the Convention. With an efficient Executive Staff to implement the plans in detail, the One Hundred Fifth Annual Convention should focus the attention of the membership on Asheville in May.

/s/ John S. Rhodes, M. D., Chairman Joshua F. B. Camblos, M. D. Millard D. Hill, M. D. Theodore S. Raiford, M. D.

COMMITTEE ON SCIENTIFIC AUDIOVISUAL POSTGRADUATE INSTRUCTION

The Committee has arranged an Audiovisual and Postgraduate Instructional Program which will be presented on Sunday, May 3, and Monday, May 4, 1959, during the annual meeting at Asheville, North Carolina. The meeting will be held in the City Auditorium Assembly Hall.

Subjects of general interest will be presented and will cover surgical problems, urological reconstruction, physiology of gastric function, certain problems in cancer, safety in x-ray techniques and respiratory acidosis.

No formal panel discussions have been arranged because of the limited attendance at previous meetings. The members of the Audiovisual Committee will act as discussors of the individual presentations and the audience will be encouraged to participate.

The Sunday program, in particular, should be emphasized by a special letter to the members of the Medical Society. Adequate

signs should be available outside of the Auditorium indicating where the meeting is to be held.

It is suggested that the Academy for General Practice be questioned as to what subjects they would like presented in 1960 and that the Academy be urged to encourage its members to attend the Audiovisual and Postgraduate courses.

/s/ J. Leonard Goldner, M. D. Chairman

COMMITTEE ON SCIENTIFIC WORKS AND AWARDS

The Committee on Scientific Awards exercised its usual function at the State Society Meeting in Asheville in May, 1958, which consisted of viewing and judging motion picture presentations, scientific exhibits, and other audio-visual media. The membership of the Committee was well represented, and all members present cooperated in the work to be done.

Since then the name of this Committee has been changed to that of Committee on Scientific Works and Awards. There are no additional activities to be reported other than the usual one of appraising manuscripts, which were presented at last year's meeting. This appraisal is still in progress, but is necessarily having to be done by a very restricted membership of the group, owing to the fact that the manuscripts were not submitted to the Committee until early March. This is unfortunate, in view of the fact that we now have a large, and well organized Committee, whose organization it is impossible to fully and adequately utilize this year.

/s/ Rowland T. Bellows, M. D., Chairman

COMMITTEE ON BLUE SHIELD

The 1958 Blue Shield Committee of the North Carolina State Medical Society, duly appointed from Dr. Lenox D. Baker, President, and under authority of letter from the office of James T. Barnes, Executive Director, consisted of the following members:

W. Z. Bradford, M. D.
William H. Flythe, M. D.
Willard C. Goley, M. D.
John R. Hoskins, M. D.
Julius A. Howell, M. D.
Robert W. King, M. D.
L. L. Klostermyer, M. D.
Louis C. Roberts, M. D.
Max P. Rogers, M. D.
J.H. Shuford, M. D., Chairman

The Committee met a total of four times and diligently attempted to carry out its assigned duties. The Committee invited Dr. John C. Reece, President-Elect, to attend all Blue Shield meetings and he was generous enough of his time to attend three State Meetings and one National Blue Shield Meeting in Chicago. 1,630 physicians have signed to participate in the Blue Shield Doctors Program; an increase of 71 participating physicians since 1 March 1958 (see attached breakdown by county and district - Exhibit 1). As of 31 December 1958 persons covered by the Doctors Plan Medical and Surgical Riders were as follows (see attached Enrollment Report - Exhibit 2).

The Blue Shield Committee had envisioned two main objectives in its 1958 program:

1. The integration of Hospital Care Association of Durham, North Carolina, into the Blue Shield Doctors Program, and the recognition of Hospital Care as a Blue Shield agency allowed to sell said program.

2. The stimulation of participation and interest in the Doctors Program among the members of the North Carolina State Medical Society.

Due to the failure of Hospital Care Association to fulfill and carry out the requirements and regulations as set forth by the House of Delegates in session at Asheville, North Carolina, on 5 May 1958, the Executive Council meeting in Raleigh, North Carolina, on 21 September 1958, directed the Blue Shield Committee to proceed no further with integration of Hospital Care into the Blue Shield Program until such time as the Council directed otherwise.

The Committee in an effort to stimulate participation in the Doctors Program recommended that Blue Shield Subcommittees be set up on a District basis. A Subcommittee on Professional Relations was appointed by the Chairman consisting of Drs. Rogers, Klostermyer, and King. This Subcommittee met with Hospital Saving Association representatives and outlined the following program:

- 1. Announcement in the Medical Society Public Relations Bulletin regarding the workings of the Blue Shield Committee with emphasis on the fact that the Committee is an instrument of the Medical Society and announcing the revised printing of the Fee Sched-
- 2. Publication of an article about Blue Shield in the Medical Journal. (Note:

This appeared in the November, 1958 North Carolina Medical Journal).

3. Distribution of a letter to all doctors mailed with the new edition of the Fee Schedule. An agreement form accompanied the letter to those doctors not participating.

4. Appointment of a three-man District Blue Shield Committee by nomination of the District Councilor. Through District Committees thus appointed,

arrange for the following:

District workshops for doctors' office secretaries and assistants.

В. Speakers to discuss Blue Shield at District and County Medical Society meetings.

Act as grievance committee on

local level.

The following District Subcommittees on Blue Shield have been appointed from lists of names supplied by the respective District Councilors:

Frank Wood, M. D., Chairman, Eden-I. ton; William M. Atkins, M. D., Windsor;

Archie Y. Eagles, M. D., Ahoskie.

II. John W. Morris, M. D., Chairman. Morehead City; Fred P. Brooks, M. D., Greenville; R. Vernon Jeter, M. D., Plymouth.

III. James S. Brewer, M. D., Chairman, Roseboro; William W. Kitchin, M. D., Clinton; William A. Greene, M. D., Whiteville.

IV. John W. Compton, M. D., Chairman, Goldsboro; Robert D. Kornegay, M. D., Rocky Mount; Robert L. Tomlinson, M. D., Wilson.

V. Thad B. Wester, M. D., Chairman, Lumberton; Joseph S. Hiatt, Jr., M. D., Southern Pines; Harry H. Summerlin, M. D., Laurinburg.

VI. Isaac E. Harris, Jr., M. D., Chairman, Durham; William J. Senter, M. D., Raleigh; Alexander W. Simmons, M. D., Bur-

lington.

VII. Ladd W. Hamrick, Jr., M. D., Chairman, Concord; Harry V. Hendrick, M. D., Rutherfordton; O. Hunter Jones, M. D., Charlotte.

VIII. O. Norris Smith, M. D., Chairman, Greensboro; Louis deS. Shaffner, M. D., Winston-Salem; John M. Hall, M. D., Elkin.

IX. Roy A. Agner, Jr., M. D., Chairman, Salisbury; Paul McN. Deaton, M. D., Statesville; David C. Smith, M. D., Lexington.

X. Jack C. Horner, M. D., Chairman, Spruce Pine; Ralph S. Morgan, M. D., Sylva; James D. Lutz, M. D., Hendersonville.

All members of District Blue Shield Committees were invited to meet with the State Blue Shield Committee on March 26 in Winston-Salem to discuss function of District

PROPOSED SENIOR CERTIFICATE COVERAGE FOR PERSONS AGE 65 AND OVER

SURGERY AND ANESTHESIA

Basic Blue Shield

\$200 DOCTORS PROGRAM SCHEDULE

Benefits paid at 75% of scheduled allowances. Up to \$10 (indemnity allowance) for office x-rays for accident injury.

MEDICAL ENDORSEMENT

For non-operative inpatient admission \$5 first day, \$3 second through nineteenth day, \$2 twentieth through thirtieth day (amounts suggested by National Blue Shield—could be extended to 120 days if necessary for small additional rate).

RADIATION ENDORSEMENT*1
CANCER THERAPY

Radiation tharapy for cancer in or out of hospital at Doctors Program fee allowances.

DIAGNOSTIC X-RAYS

Diagnostic x-ray examinations in or out of hospital. Benefits at 50% at Doctors Program fee allowances—patient responsible for remaining 50%.

INCOME LIMITS*2

\$1,500 individual, \$2,400 man and wife (approximate maximum Social Security payments). As a special Blue Shield Program sponsored by the Medical Society of the State of North Carolina to aid and encourage voluntary health insurance for persons 65 years of age and over participating physicians agree to accept scheduled allowances as full payment for persons who hold "Senior Certificate" coverage who have no additional coverage for professional services, and are within the income limits.

AGE LIMITS

____65 minimum, NO maximum

UNDERWRITING, GENERAL PROVISIONS

AND EXCLUSIONS

Same as regular Blue Cross and Blue Shield coverage. Benefits for conditions existing at time of application may be excluded by Rider. Conditions pertinent to the risk not disclosed on application is cause for cancellation.

COST'S - (Estimated)

Per month, per person

^{*}It is suggested that Radiation allowances be 100% of scheduled fees because of the larger element of overhead fixed cost in Radiology (subject to Blue Shield Committee decision).

^{*2} This is a tentative proposal for the Blue Shield Committee and is not official or effective unless and until adopted and approved by the Blue Shield Committee and the House of Delegates of the State Medical Society.

Committees and to help decide on a recommendation to the House of Delegates of 1959 regarding a special coverage for persons of limited income age 65 and over.

Thirty people attended this meeting. Dr. Edward U. Austin, Chairman of the Dental Society's Insurance Committee, spoke of the Dentist's problems with regard to health

insurance.

The newly appointed Blue Shield District Committees were acquainted with current problems and objectives of the State Committee and requested to stimulate active interest in Blue Shield in the County Medical Societies of their Districts.

Due to the socialistic threat of the Forand Bill, the AMA has requested all State Medical Societies to vigorously encourage voluntary health insurance for persons over 65 and to provide services at reduced fees for older

persons of reduced income.

At this meeting the joint Committees reviewed the following tentative information prepared by Hospital Saving Association at the request of the Chairman as to possible rates and benefits for coverage of senior citizens. After discussion of all the ramifications, the Committee deferred any specific recommendation to the House of Delegates for service benefits at reduced fees and income limits for persons 65 and over until further consideration could be given at future meetings.

The Committee was honored by the presence of Dr. Amos Johnson, Chairman of the Medical Society's Committee on Negotiations. on 30 October 1958. A discussion on matters pertaining to negotiation as it affected Blue Cross and Blue Shield was held, Dr. Johnson and the Blue Shield Committee were in agreement as to mutual aid as the need for any negotiation might arise.

The Committee authorized Hospital Saving Association to sell medical and radiation benefits of the Doctors Program under separate Rider. This was done so that persons already covered for irradiation and diagnostic x-rays under the Association's "Extended Benefits" coverage could buy medical benefits for non-surgical inpatient care without duplicating radiation benefits. The Association also believes this separate Rider will permit some persons to buy radiation benefits who could not afford the complete Medical Rider.

The Committee considered in detail a request by the Dental profession to participate in Blue Shield benefits. Mr. Cradford of Hospital Saving Association reported that certificate provisions limited benefit payments to licensed physicians, except that in

cases of fractured jaws the Blue Shield Committee had authorized payment to Dentists under the Doctors Program. He said that the Association's Enabling Act would permit development of a "Dental Rider." This could be offered to the public as a separate Rider at an additional charge, as the rate established for existing surgical coverage does not provide benefits for dental procedures. However, he felt that the Physicians and Dentists must first set up a list of procedures, nomenclature, and fees which were agreeable to both professions before Hospital Saving Association could proceed with this type of coverage. The Committee felt that no definite action by the State Society should be taken until careful consideration of all aspects of this question were completed. A motion was made and passed by the Committee recommending that "a program of remuneration for dental surgery is, at the present time, not in the best interests of the Doctors Program or the Medical Profession." The feeling of the Committee was unanimous that certain delicate questions as to the scope of Surgery involved must be carefully delineated and full agreement be reached between the Professions. It was felt that to proceed without this complete understanding would lead to alienation of participating physicians and thus harm the Blue Shield Program.

We, of the Committee, wish to thank Hospital Saving Association and its officials for their fine cooperation in implementing the Doctors Program. We wish to thank Mr. James T. Barnes for his never-ending advice and help. And, I, wish to express my sincere gratitude to the members of the Blue Shield Committee for their interest and devotion to

the Doctors Program.

Respectfully submitted. J. H. Shuford, M. D. Chairman

Estimated

Number Phy-

sicians Number

EXHIBIT 1 BLUE SHIELD PARTICIPATING PHYSICIANS BY COUNTY AND DISTRICT

	In Active Practice	%	
First District			, .
Bertie	9	4	44
Chowan-Perquimans	10	3	30
Gate	2	1	50
Heartford	14	7	50
Pasquotank - Camden	25	8	32
Currituck - Dare			
Total	60	23	38

Second District Beaufort (including Carteret Craven Lenoir - Greene - Jon	18 25 nes 39	15 14 12 16 5	75 78 48 41 29	Seventh District	In Activ		%
Martin - Washington Tyrrell	11 - 11	J	<u> </u>	Anson	9	5	56
Pamlico	3	2	67	Cabarrus	55	10	18
Pitt	41	37	90	Cleveland	41	29	71
Total	163	101	62	Gaston Lincoln	70	$\frac{32}{7}$	$\frac{46}{70}$
Third District				Mecklenburg	$\begin{array}{c} 10 \\ 270 \end{array}$	84	31
Bladen	11	4	36	Montgomery	8	5	63
Columbus	21	20	95	Rutherford	$2\overset{\circ}{3}$	11	48
Duplin	16	10	62	Stanly	$\overline{23}$	15	65
New Hanover (inclu		59	80	Union	16	6	38
Brunswick and Pe	ender) 13	8	61	Total	525	204	39
Sampson	18	$1\overset{\circ}{2}$	67	Eighth District			
Total	153	113	74	Ashe	7	5	71
10001			• -	Forsyth - Stokes	200	103	52
	Estimated			Guilford	207	118	57
	Number Ph	y- Number		Randolph	25	20	80
	In Active			Rockingham	30	12	40
	Practice		%	Surry - Yadkin	37	20	54
Fourth District	Tractice	cipating	70	Watauga	$\frac{9}{21}$	$\frac{4}{16}$	$\begin{array}{c} 44 \\ 76 \end{array}$
Edgecombe - Nash	58	15	26	Wilkes - Alleghany Total	$\frac{21}{536}$	298	56
Halifax	26	15	58	Total			30
Johnston	31	7	22		Estimate		
Northampton	6	3	50		Number Pl		
Warren	8	2	25		sicians	Number	
Warren Wayne	8 41	$\begin{array}{c} 2 \\ 29 \end{array}$	$\frac{25}{71}$		sicians In Activ	Number e Partici-	67
Warren Wayne Wilson	8 41 33	2 29 28	25 71 85		sicians In Activ	Number	%
Warren Wayne	8 41	$\begin{array}{c} 2 \\ 29 \end{array}$	$\frac{25}{71}$	Ninth District	sicians In Activ Practice	Number e Partici- e cipating	, -
Warren Wayne Wilson	8 41 33 203	2 29 28 99	25 71 85 49	Ninth District Avery	sicians In Activ Practice	Number e Partici- e cipating	78
Warren Wayne Wilson Total Fifth District Chatham	8 41 33 203	2 29 28 99	25 71 85 49	Ninth District Avery Burke	sicians In Activ Practice	Number e Partici- e cipating	, -
Warren Wayne Wilson Total Fifth District Chatham Cumberland	8 41 33 203 12 54	2 29 28 99 10 46	25 71 85 49 83 85	Ninth District Avery	sicians In Activ Practice 9 30	Number e Partici- e cipating 7 23	78 77
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Warren Wayne Wilson Total Fifth District Chatham Cumberland Harnett Hoke	8 41 33 203 12 54 18 8	2 29 28 99 10 46 13 5	25 71 85 49 83 85 72 62	Ninth District Avery Burke Caldwell Catawba Davidson Iredell - Alexander	sicians In Activ Practice 9 30 23 47 37 47	Number e Partici- e cipating 7 23 19 37 24 35	78 77 83 79 65 74
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EXHIBIT 2

DOCTORS PROGRAM ENROLLMENT REPORT "D" "H" "J" "L"												
		Surger \$4,20			Surgei Surgei			Medica \$4,200			ledic - \$6.	al
Enrollment Year End	56	57	58	56	57	58	56	57	58	56	57	58
Group Certs. Dependents		12,341	25,928 48,329		1,368	2,057	852	3,960	5,902	281	668	638
			40,028	1,565	4,298	3,498	529	2,473	3,706	176	409	389
Total Participants Non-Group	12.070	34,827	74.257	2,217	3,666	5,555	852	3,960	5.902	2 81	668	638
Certs. Dependents		$\frac{3.944}{4.672}$		$\frac{198}{142}$	$\frac{279}{222}$	$\frac{347}{337}$			1,726 1,863	$\frac{120}{51}$	156 95	140 104
Total										-		
Participants Total Certs. Total		8,616 $16,285$		$\frac{340}{1,030}$	$501 \\ 1.647$	684 $2,404$			3,589 3,922		$\begin{array}{c} 251 \\ 415 \end{array}$	
Dependents	9,993	27,158	55,346	1,527	2,520	3,835	1.244	3,978	5,569	227	504	493
Total Participants	16.161	43,443	87,072	2,557	4.167	6,239	2.343	7,074	9,491	452	919	882
HOSPITAL SAT CHAPEL HILL	VING . , NORT	ASSOCI TH CAF	ATION ROLINA									

COMMITTEE ON RELATIVE VALUES

The Committee on Relative Value has been working since its appointment to form subcommittees in each specialty in order to draw up a Relative Value Schedule for North Carolina. It is not felt that any suitable schedules can be submitted to the Executive Council prior to 1960.

Everett I. Bugg, Jr., M. D. Chairman Dr. Louis Roberts Dr. Alfred Hamilton Dr. Jacob H. Shuford

COMMITTEE ADVISORY TO NORTH CAROLINA STATE BOARD OF PUBLIC WELFARE

Your Committee to advise with the State Board of Public Welfare has had three meetings with Dr. Ellen Winston, Commissioner of Public Welfare, and members of her staff during the fiscal year. The first meeting was held on the afternoon of July 13, 1958, and lasted three hours. Several new members who had not heretofore served on the committee were welcomed.

At this meeting the roll of the Committee and its functioning as an Advisory Committee to the State Board of Public Welfare was reviewed for the benefit of the new members by Dr. Ellen Winston. Commissioner. Following this review we went into consideration of a number of items of procedure that had medical implication such as, for example: the adoption of proper forms for the obtaining of medical information and the approval of certain forms for obtaining certain information from nurses and lay people. Other items involved, day nurseries. nursing homes, homes for the aged. etc., too numerous to mention here. In these instances the Committee and Dr. Winston agreed on methods and forms of procedure.

On October 31, 1958, the Advisory Committee again met with Dr. Ellen Winston, Commissioner of Public Welfare, and certain members of her staff. At this meeting the A Budget and B Budget, which the State Board of Public Welfare proposed to present to the Advisory Budget Commission, was discussed in some detail. Your Committee was able to agree with the proposed budget in most details and certainly with the overall principles involved. Recommendation was later made to the Executive Council that the Medical Society should support the budget of the State Board of Public Welfare when presented to the Legislature. At this meeting Dr. Winston explained the need for an appropriation from the state to assist the counties in a general assistance program. As you know, our counties spend considerably, actually about 21/2 billion dollars a year, for general assistance to the needy people who cannot qualify under one of the four categories of old age, totally

and permanently disabled, dependent children, and the blind. These people present a real need and in most instances they represent the type of people for whom assistance is only temporary and who will be returned to work. The Committee felt strongly that the state should contribute something to help the counties with this type of case. The request was for \$500,000.00 a year from the state.

Some time was also given to the discussion of the illegitimate problem. That is the problem of the women who repeatedly bear illegitimate children for which the ADC program contributes to support. This problem seems to be a hard one to solve. It was pointed out that whatever action was taken should be punitive toward the mother but not the child. The Advisory Committee felt that sterilization after the second or third illegitimate child should be required. Dr. Winston stated that the question had been raised as to whether such procedure would be constitutional.

February 1, 1959, the Committee again met with Dr. Winston and certain members of her staff. At this meeting a review of the total legislative program of the State Board of Public Welfare was presented by Dr. Winston. We also discussed development in the board home program for the aged and the purchase of skilled nursing service for aged patients. We also discussed certain policies with reference to tuberculosis sanatoriums, drugs for indigent patients and the homemaker services of the welfare program.

On September 10, 1958, your chairman had the privilege to attend a meeting of the Southeastern Regional Conference, American Public Welfare Association, Roanoke, Virginia, and presented a paper before one of the sessions on "What Referring Physicians Should Know About Public Welfare Services." Your chairman was pleased to learn again how highly the public welfare program in North Carolina is regarded and how favorably it compares with that of our sisterly states.

On February 18, 1959, your chairman spoke before the Joint Appropriations Committee of the North Carolina General Assembly in support of the welfare program and proposed budget stressing particularly the need of increased payments to our hospitals and the need for an appropriation from the state to assist the counties in a general assistance program.

From time to time the Advisory Committee has discussed with the Commissioner of public welfare the problem of medical and hospital care for our aging population. While it appears there is danger that we go into a welfare state in this country, it is well for us to remember that there are several million people who because of age or disability are not able to provide for medical and hospital care. Our philosophy of life in this country has now reached the stage where sickness care and the advantage of modern medical and surgical and hospital care is to be given to every needy person, the same as education, to every child, regardless of inability to pay. This being true, it follows that this can be done by some sort of pre-payment insurance program or by public assistance grants from tax funds.

Let me as chairman of your committee urge that our Medical Society continue its present relationship with the State Board of Public Welfare through the Advisory Committee. It is important for the Society as physicians to know what is going on in a medical way in the welfare department. Likewise, it is worthwhile and a benefit to the State Board of Public Welfare to have the advice and the approval, and sometimes the criticism, of the Committee from the State Medical Society. Our relationship to date has been most friendly and cooperative with each other.

s/ J. Street Brewer, M.D., Chairman Allyn B. Choate, M.D.
H. Fleming Fuller, M.D.
Robert D. Higgins, M.D.
J. Kempton Jones, M.D.
William W. Noell, M.D.
Bruce B. Blackmon, M.D.

COMMITTEE ON CANCER

The first meeting of the Cancer Committee was held November 1, 1958, at the Hotel Sir Walter in Raleigh, Attendance was poor and little was accomplished.

The Committee next met at the same place the 17th of January, 1959 with the following members present: Dr. Sam Parker, Dr. C. I. Harris, Dr. Isaac Harris, Dr. George Bell, Dr. R. Bertram Williams, Dr. Charles G. Mock, Dr. Grover Bolin, Dr. William Bell, and Dr. John Kernodle from the Liaison Committee.

The first order of business was the presentation by the Chairman of the 10 points of the recommendation by the Commission, appointed by Governor Hodges, To Study the Cause and Control of Cancer in North Carolina. They are as follows:

Cytology
1. That there be developed by and through the cooperation of appropriate agencies full utilization of all presently existing facilities, an expansion of the program of

Cytology, that the program include solicitation of outstanding clinical microscopists, technicians, bio-technicians, college students and others of sufficient moral and intellectual probity to enter the field of Cytotechnology. That a fund be established to be administered by the Cancer Section of the State Board of Health, in conjunction with the Cancer Committee of the North Carolina Medical Society, and the North Carolina Association of Pathologists, in the amount of Fifty Thousand (\$50,000) Dollars per year, for students to be trained in accredited laboratories in the State of North Carolina as approved by the above named administrators of the fund, as cytotechnologists. A maximum subsidy of \$2,500 may be paid per individual per course. The subsidy shall be paid to the accredited and approved laboratory and used exclusively for maintenance, teaching and salary of the student. student accepted under this program shall agree to work as a cytotechnologist in the field of exfoliative cytology in the State of North Carolina for a period of three years. If any student under this program shall fail to complete the required course or shall fail to work for a period of three years as aforesaid, then such subsidy shall be repaid in full.

Research Facilities

2. That there is a need for additional cancer research in North Carolina, and that there be established at the University of North Carolina an expansion of facilities necessary for cancer research and educational programs, including chemotherapy and other recent developments for the detection and treatment of cancer. That the research facility be organized, to the extent possible along the lines of the Gravely Institute in agreement with the University of North Carolina administration. This program is urgent and should be acted upon and implemented immediately.

State Board of Health

- 3. That the State Board of Health be commended for its efforts in developing and promoting Cancer Control and that means be provided for continuation and expansion of its program, including, specifically in addition to other recommendations herein made, the appropriation requested for its Cancer Treatment Program of \$235,000 per year and the three day hospitalization program for essential diagnosis of \$75,000 per year.
- 4. That there be developed a fully adequate statistical service within the Public Health Service so that theer may be effectively recorded full information regarding cancer, and that such statistical data be

evaluated and made available to those desiring and requiring the same, and that in the promotion of this program, that Tumor Registries be set up, that the cooperation of the medical progression be secured, that the hospital administrators be especially solicited in compiling and furnishing information, and that the experience, information and assistance of the American Cancer Society be secured and coordinated in the development of the program.

N. C. Cancer Institute

5. That the services of the North Carolina Cancer Institute, at Lumberton, be commended and approved, and that appropriations be made for its continuance, and that appreciation be expressed to those who have so long volunteered and provided services, both medical and lay, resulting in greatly reduced operating costs.

Cancer Education

6. That the State Board of Education be encouraged to increase cancer education in the public schools, beginning at the sixth grade level and continuing in the curriculum throughout high school.

7. That the North Carolina Division of the American Cancer Society be commended for its efforts in adult education and that it be encouraged to expand in the areas of lay and professional education.

8. That the Medical Society of North Carolina, particularly the Cancer Committee, be commended for their work and encouraged to promote cancer education among the physicians of the State.

State Board of Public Welfare

9. That the State Board of Public Welfare be commended for its program for the maintenance and care of the indigents of the State. That the current efforts of the State Board of Public Welfare and the State Board of Health to develop within existing agencies, a practical plan for essential drugs for the indigent be commended. The Commission expresses the desirability of fair and equitable financial participation of all counties in any program relating to drugs and every possible safeguard in the administration or use thereof.

Continuity

10. That the existence of the Commission be continued for the effective use of assembled information and to study means of implementing these recommendations and to assist in their development.

These were discussed and specified action

taken on 5 of them as follows:

1. That the amount of money appropriated by the legislature for the diagnosis and treatment of indigent patients with cancer

be increased and that counties be urged to match the State and Federal funds when applied to individual patients with cancer.

2. That the Cancer Committee adopt as one of its major programs, in conjunction with the Cancer Society and the State Board of Health, the taking of Papanicolaou smears by all physicians doing complete and/or pelvic examinations on women. In addition, that the legislature be urged to appropriate funds for the training of cyto-technicians in order that there be sufficient personnel to carry out the program.

3. That the North Carolina Cancer Institute remain at Lumberton, and that the physicians treating those patients be commended for their unstinting and unselfish

work.

4. That the pathologists in the State be requested to report cancer cases to the State Board of Health, as required by law, so that these statistics will more nearly approach the actual number of cases in North Carolina and some conclusions can thereby be drawn as to the number of cases present and at some future date, one can determine whether or not progress is being made in the cure of cancer in this State.

5. And finally, that additional State funds be appropriated for cancer research facilities at the North Carolina Memorial Hospital

at Chapel Hill.

The Committee again discussed the use of the Federal and State funds for the treatment of indigent patients with cancer in regard to those requests that came in from time to time for use of these monies for palliative therapy. It has been the policy of the State Board of Health, as recommended by this Committee, to allocate these funds only for those patients who have a chance of cure. Even so, the funds are always exhausted long before the fiscal year ends. It was the opinion of the Committee that this policy be continued.

The Committee would like to urge that those county societies that have not had a program on exfoliative cytology, particularly as related to the cervix, please do so. Speakers can be provided by the Committee Chair-

man.

There has been close cooperation between the American Cancer Society, the State Board of Health, and this Committee this year as in the past. It should be pointed out that one half of the directors of the State Division of the American Cancer Society are members of the Medical Society of the State of North Carolina.

> /s/ James F. Marshall, M.D., Chairman

George E. Bell, Jr., M.D. William H. Bell, Jr., M.D. Grover C. Bolin, Jr., M.D. William R. Bosien, M.D. Joshua F. B. Camblos, M.D. Charles I. Harris, Jr., M.D. Charles Glenn Mock, M.D. Charles Glenn Mock, M.D. Samuel L. Parker, Jr., M.D. David L. Pressly, M.D. R. Bertram Williams, M.D.

COMMITTEE ON CHILD HEALTH

The work of the Child Health Committee has been entirely through the Sub-Committee on Neonatal Deaths. The Neonatal Death Study began in 1956, and for 1956 and 1957 included only those hospitals having 500 living infants annually. In 1958 it was expanded to include all hospitals and clinics that deliver more than 100 living infants annually. This Neonatal Death Study Committee is now a joint sub-committee of the Child Health and Maternal Welfare Committees. Plans are under way for a summary of the first three years' information. Data are to be sent to each hospital that has participated for self evaluation in terms of neonatal mortality. The Child Health Committee is now in the process of perfecting a blank for recording pregnancy, labor and delivery data as well as the newborn examination. This will give more accurate data on the newborn infant from hospital records especially in small hospitals or clinics. The Neonatal Death Study is continuing during 1959. We hope the same excellent cooperation from the participating hospitals and clinics will be continued.

/s/ Angus M. McBryde ,M.D.,
Chairman
Richard W. Borden, M.D.
Edward C. Curnen, Jr., M.D.
Clyde R. Hedrick, M.D.
Paul F. Maness, M.D.
Lewis S. Rathbun, M.D.
Robert L. Vann, M.D.

COMMITTEE ON CHRONIC ILLNESS

The Committee on Chronic Illness has continued to follow through on its original purposes, these are: (1) to promulgate the education of the people and physicians to the ever increasing problem of chronic illnesses and to the lack of facilities adequate to care for these throughout our State; (2) to study and influence the passage of all legislation related to the problems of chronic illness and aging in the present General Assembly, and in Washington, and (3) to study, evaluate,

and influence medical progress in the field of aging.

The Chairman and members of the Committee and of the State Medical Society have attended and participated in numerous national, state, and local conferences and program planning sessions, all aimed at these same basic problems connected with either chronic illness or the aged. Since the report last year, the Joint Council for the Health Care of the Aged has prepared and publicized its program of study and operation. The Joint Council is made up of representatives of the American Medical Association, American Hospital Association, American Dental Association, and the National Association of Boarding and Nursing Homes. Each state is now being encouraged to form similar Councils on the state level. North Carolina had already expanded its core of representation in 1958 at which time a coordinated committee meeting was held with representatives invited from Public Health, State Board of Public Welfare, Hospital Care Commission, Commission of Nursing Homes, Commission on Aging, Commission on Cancer Control, and the Geriatric Research Program at Duke University under the direction of Dr. E. W. Busse. In March 1959 this group met together again and in addition had representatives from the American Red Cross; School of Public Health, Chapel Hill; North Carolina Association of Boarding and Nursing Homes; and the Insurance Industry Health Committee. At the request of this coordinated group, the Chairman of the Medical Society's Committee on Chronic Illness was asked to give a more permanent status to this joint group so instead of limiting the Council to the original four organizations of the National Joint Council, North Carolina has named this group: A Joint Committee for the Health Care of the Chronically Ill and Aged. This action was approved at the last Committee meeting, March 14, 1959.

The Committee has continued to keep in touch with the demonstration programs which are being conducted by Public Health in Person County by Welfare through the Homemakers Service Programs, and a new training program for nursing aides being inaugurated by the American Red Cross.

The Guilford County Survey on Chronic Illness completed in 1958 has given this Committee a base from which to study and evaluate the needs and services of both groups. the chronically ill and the aged, primarily those of the chronically ill. In the late Fall of 1958, a sub-committee was formed with the responsibility of assisting local county medical societies in setting up and organiz-

ing committees on chronic illness. One member of the State Committee was named chairman and the results to date show that 43 local chairmen have been so named, representing 52 of the counties in the state. Several of these county committees are busy making local surveys, evaluating present facilities and services, and making recommendations for improvements at the local level.

Following the recommendations made last year, the Committee has followed through

by:

- 1. Continued efforts to alert all people of the problems of the aging and the chronically ill. Committee members have participated on state and local program, pointing up the survey findings of the Guilford County Study, the Medical Society Study made last year, and results of out-of-state studies that proved to be practically the same as the studies made in this state. To name a few would be: the annual conference for Social Service in 1958. District Rural Health Conferences sponsored by the State Medical Society, Officers Conference for County Medical Societies, a special T. V. program over WUNC-TV in January of 1959, and participation in national conferences and planning sessions for future programs on these health and medical service needs.
- Development of adequate facilities for the health care of the aged. The Medical Care Commission reports that North Carolina ranks second in the nation as to the number of beds for the chronically ill, either constructed, under construction, or approved. Some 402 beds to date. The Committee has supported the legislative requests of the Governor's Commission for Boarding and Nursing Homes and the State Board of Public Welfare in encouraging a mandatory license for all homes caring for the chronically ill or aged for North Carolina. There has also been expressed interest in securing loans, either from the Small Business Association or F. H. A. for the construction of approved nursing homes for private operation.
- 3. Continue the study and encouragement of financial assistance for the chronically ill. Again, the Committee has supported the efforts of the State Board of Public Welfare in its request for a State Appropriation for General Assistance to match present county funds. These funds would be made available to non-category grants-in-aid recipients. A request in the B. Budget for Public Welfare is for \$500,000.00 per year for the biennium.

Another legislative request that this Committee has supported is the Medical Care Commission's request for an increase in per

diem payment for medical indigents. crease from \$1.50 to \$2.50 per day per patient. As an aid to improve hospital losses for the indigents, support has been given to the State Board of Public Welfare's request for an increase in the "pooled hospitalization" fund. An increase from \$8.50 to \$10.00. This was also included in the B. Budget.

At this time, no definite action has been taken by the General Assembly on State De-

partment requests.

Another major source for financial aid for the care of the chronically ill and aged is through pre-payment insurance. The Committee has continued to work with the Insurance Industry's Health Committee and with Hospital Saving Association encouraging extended benefits and for out-patient coverage, including payments for approved nursing home care.

The Medical Society's Committee on Blue Shield met recently and reviewed this problem with the Chairman of the Committee on Chronic Illness present. There was much interest expressed and a sub-committee was asked to give further study and make its recommendations to the House of Delegates in May. There was much discussion as to the pros and cons of Service versus Indemnity policies for the group over age 65. The Insurance Industry has made progress towards meeting the needs of our older citizens and much more is expected during the year. This is the best approach to combat Forand type of legislation.

Encourage and sanction the development of visiting nurse and organized home care programs and home maker services. The County demonstration Person through the Public Health Service is proving most effective in assisting the family members to give better care in the home and also has reduced the number of days of hospitalization for chronically ill and aged patients. This is a three year project being financed by the Public Health Service and the State Board of Health. Two public health nurses, one physio-therapist and a nutritionist, have been added to the local staff of the health department and they hope to add a social worker before the end of the year. These public health workers render service to outpatients under the direction and supervision of the local physicians. All reports indicate this to be a most successful project and it is the only rural demonstration project of its kind in the nation. National interest has been great and a report of the project will be given to the five-state medical meeting in Salt Lake in May 8, 1959.

Through the State Board of Public Welfare,

North Carolina has seven home-maker service programs. Two other programs are carried out by Social Service Agencies. Three of the seven welfare programs are being used as demonstrations in rural counties: Chatham, Alamance and Harnett. One white and one colored home-maker has been added to the county welfare staff and work under the direction of the Case Work Supervisor. Approximately 1100 visits have been made to some 85 people during the year in the three demonstration counties which have proved most helpful to the patients and to the family members in giving improved health services to the individuals. It is hoped that in the future additional home makers can be added so that these same services can be rendered to all citizens, and not restricted to category recipients. This is true in the five programs, other than the three demonstration projects.

Disapproval of the Forand Bill and continue efforts to develop a positive program to counteract this legislative action. The A. M. A. Committee on Aging has this year prepared a positive health program for older citizens with its six-point action pro-

posal. These are as follows:

 Stimulation of a realistic attitude toward aging by all people.

Extension of effective methods of financing health care for the aged.

Expansion of skilled personnel training programs and improvement of medical and related facilities for older people.

4. Promotion of health maintenance programs and wider use of restorative and re-

habilitative services.

5. Amplification of medical and socioeconomic research in problems of the aging.

6. Leadership and cooperation in com-

munity programs for senior citizens.

The Committee on Chronic Illness has attempted to follow through on these six points in planning its activities throughout the year. The objectives are the same and the work of the North Carolina Medical Society's Committee has been cited as one of the more

advanced programs in the nation.

Future programs of importance to this Committee include: (1). State Conference on Aging being planned for 1960; (2) White House Conference on Aging in 1961: (3) Joint Council meeting scheduled for Washington, D. C., in June 1959, and a regional Conference sponsored by the National Assembly of Social Welfare for 1960, and a workshop to be sponsored by the North Carolina Conference for Social Service in the fall of 1959. In addition to the planned national. regional, and state conferences to continue

the study and evaluation of the health and medical needs of the chronically ill and aged. a proposal made by the Society's Committee has been approved by the North Carolina Hospital Association to conduct a survey across the state on the hospital length of stay and means of payment for persons over 65 years of age. The survey forms are to be prepared by the State Medical Society and the information collected by the inddividual hospitals and will be spaced at regular intervals during the year (seasonal winter, spring, summer, and fall) of one week's occupancy each. The survey will attempt to collect data on: first, the length of stay of persons in the hospital (each of these four weeks) who are over 65; and second, what means of payment for hospitalization - insurance, family, individual, welfare, or other. This data will be most valuable in establishing a basis on the cost of medical and hospital services to this segment of our population. It should be helpful to insurance companies who are seeking some basis for policy premiums and the risks allowable.

Recommendations:

1. Continuation of the Committee on Chronic Illness with increased emphasis given to the formation and organization of local society committees on chronic illness. Encourage representation of all agencies and organizations engaged in either a service or educational program for the health care of the chronically ill or aged.

2. Continued support given other agency service programs that will assist with home

care programs.

- 3. Recommendation to the Executive Council and the House of Delegates to continue their support of legislative requests from the State Board of Health. State Board of Public Welfare, Medical Care Commission, and specifically Governor's Commissions which have direct effort on the health care of the chronically ill and aged in North Carolina.
- 4. Strengthen the cooperative efforts of the Joint Committee for the Health Care of the Chronically Ill and Aged.
- 5. Continue working with Insurance companies, both Blue Shield-Blue Cross and Commercial for expansion of policy coverage and benefits to persons over 65.
- 6. Encourage a positive action on the Insurance Resolution passed by the A. M. A. in 1958. Consider the recommendation of the A. M. A. Blue Shield Committee and the action taken by the Iowa State Medical Society and Lyons County, Kansas.

7. Continuation of the liaison contacts of

the Medical Society representatives with A. M. A., National, Regional, and State programs being planned and organized for the improved health care of these two segments of our population. Maintain the leadership role already established by the Medical Society in this area of health and medical service.

John R. Kernodle, M. D.,
Chairman
James P. Alexander, M. D.
Wm. M. Coppridge, M. D.
Robert H. Dovenmuehle, M. D.
Harold D. Green, M. D.
Joseph S. Hiatt, Jr., M. D.
Emery T. Kraycirik, M. D.
Edward C. Kunkle, M. D.
Daniel A. McLaurin, M. D.
Robert L. McMillan, M. D.
Elbert L. Persons, M. D.
Kenneth D. Weeks, M. D.

COMMITTEE ON CONSTITUTION AND BY-LAWS

(Each Delegate has been furnished copy of the Constitution and By-Laws as constructed and enacted through May 7, 1958. Further report will come direct to the House in May 1959.)

s Roscoe D. McMillan, M. D., Chairman Milton S. Clark, M. D. M. D. Hill, M. D. Moir S. Martin, M. D. Louis deS. Shaffner, M. D.

COMMITTEE ON MEDICAL CREDIT BUREAU

The Committee on Medical Credit Bureau met in Winston-Salem, North Carolina, on February 27, 1959 at 7:00 P. M. Present at the meeting were: Dr. W. Howard Wilson, Chairman, presiding, Dr. M. S. Martin of Mt. Airy, Dr. Ralph Sykes of Mt. Airy, Dr. F. K. Garvey of Winston-Salem, Dr. James P. Rousseau of Winston-Salem, Mr. Odell Beroth of Winston-Salem, Mr. Gray Duval of Charlotte, (The latter two gentlemen of the Medical Credit Bureaus of those areas) and Mr. James T. Barnes, Executive Director, Medical Society of the State of North Carolina, Raleigh. An agenda for the meeting had been prepared by Mr. Barnes and in some sense this was followed in the deliberations of the committee by Dr. Howard Wilson. Dr. Wilson first reviewed the history of this committee's movement beginning with the appointment of the committee at the instigation of Dr. James P. Rousseau in 1955 and the course of the committee's deliberations and efforts during the tenure of its existence through 1958. Dr. Wilson made reference to the paper which he prepared and presented for the General Sessions of the Medical Society at the 1958 Annual Sessions and which paper was taken by Mr. Barnes to Chicago shortly thereafter and left with American Medical Association officials in the light of the interest of the American Medical Association at that time in the problem of medical credit bureau activities in the country. It does not appear that the paper has been published in the American Medical Association Journal and for that reason it has not been on file with North Carolina Medical Journal to this time. However, Dr. Wilson has a copy of the manuscript of his presentation and he is to furnish us with a copy of that and we are to determine further whether the paper is to be published by the American Medical Association and if not, it is to be published in the North Carolina Medical Journal shortly.

Reference was made to the "Federal Company" in Fayetteville requesting space at the 1959 annual meeting of the State Medical Society for the purpose of a commercial display of a collection system. It was the sense of the committee that the educational display portions of the annual sessions are restricted to general educational type of exhibits and without an exhibit qualifying in this general area it is not proper to consider it for display. It appears to be more of a single system and one would have to apply the criteria including recognition of the physician's medical credit bureau as well as the medical-dental credit bureau at the national level. We could not easily control the type of display that might ultimately be presented for exhibition. The Medical Society of the State of North Carolina could allow display only as an educational feature with the doctors. Dr. Ralph J. Sykes moved that we reject all commercial displays with medical credit collection agencies and recommend that we promote an educational display in the name of the Medical Society of the State of North Carolina devised with the aid of recognized medical credit bureaus now cooperating with the State Medical Society and to present a brief or pictorial, with manning of the exhibit carried out by rotation of members of the Committee on Medical Credit Bureaus. This motion was seconded by Dr. F. K. Garvey and upon being put to a vote, was carried. Dr. Howard Wilson is to work with our Mr. Hilliard in the development of the exhibit material and it was thought that there should be a reprint and a registration at the booth conducted by the Medical Society.

The committee expressed the hope that Mr. Duval and Mr. Beroth would aid the committee and be present in Asheville during

the presentation of the display.

Mr. Duval's explanation indicated that a lack of insurance commissioner funds and staff are two items that need strengthening in the present administration of the regulatory law governing the licensure or recognition and the regulation of credit collection agencies in the State. Mr. Duval made reference to the Southern Consumer Credit Conference conducted in Charlotte and explained the panel participation of physicians during the course of this broadly attended conference conducted in September 1958. There were 125 people in attendance (including our Mr. William N. Hilliard). The question is in getting the attendance of physicians and their office personnel, particularly the latter, as a source of training to ones personnel in the physician's office, i.e., those who are involved in the collection of physician's accounts. It was concluded that Mr. William N. Hilliard was to work with Dr. W. Howard Wilson to develop an appeal in material for the display referred to above and get from Mr. Beroth and Mr. Duval and Dr. Wilson's paper (of 1958) material for the content of the display. We suggest that any design that Mr. Hilliard could place upon paper might be transposed into art undertaking either through the facilities of Mr. Howard Hoover, Display Company of Atlanta, Georgia, or through some of the Raleigh local art media. Reference is made also in this connection to the last medical economics (probably December or January 1958 or 1959) which carried an article on this subject. The committee raised the question in developing an approved list for the Medical Society of the State of North Carolina to indicate acceptability of certain medical credit bureau collection agencies within the State of North Carolina and the committee is to consider further publication in this connection similar to what was carried on two or three years ago using at that time a public relations bulletin. In this connection, Mr. Hilliard is referred to Item 5 on the agenda for some of the answers to this problem.

It is suggested that the Medical Auxiliary people be used in the handling of the booth display in Asheville in the event that became necessary. The committee chairman raised the question of continuing the functions of this committee and recommending disposition in the annual report to the incoming President whether or not this committee should have continuity. It was the sense of the members of the committee present that the effect of the committee's existence and

intrinsic value, in maintaining vigilance against poor medical credit activities in the state, cannot be overlooked and that the committee should be maintained and this group recommends its continuation and appointment as a group function in the succeeding year and Dr. Wilson is requested to mention this in his annual report through the Commissioner to the Executive Council and to the House of Delegates. It was recommended by the committee that Mr. William N. Hilliard make reference to the planned display at the 1959 meeting through the Public Relations Bulletin of April.

Dr. Moir S. Martin referred to the good that the committee had performed in carrying out its objectives and commended the leadership which had generated the committee and carried it through its few years of efforts. Therefore, he made a formal motion that the committee go on record as approving Dr. W. Howard Wilson's effort and to encourage the continuation of the committee and it going forward with its projects. The motion was seconded by Dr. F. K. Garvey and upon being put to a vote was carried. There being no further business for the committee it adjourned about 9:00 P. M.

s W. Howard Wilson, M. D., Chairman

COMMITTEE ON DELEGATES CREDENTIALS TO HOUSE OF DELEGATES

Thank you for your reminder of the report of the Committee on Delegates Credentials to House of Delegates.

There is nothing to report except that all the delegates were properly certified.
's/ Milton S. Clark, M. D.,

Chairman

COMMITTEE ON EMERGENCY MEDICAL SERVICE AND MILITARY AFFAIRS

This Committee met on Sunday, March 1, 1959, at the Sir Walter Hotel in Raleigh. North Carolina. Those present in addition to some members of the committee were Mr. James T. Barnes, Executive Secretary, and Major Russell Nicholson of the North Carolina Office of Civil Defense. With the committee's approval opposition to the draft of physicians who are to be directed to perform services in government facilities which services could be performed in civilian facilities by civilian physicians was made to the North Carolina Delegation in Congress and Congressional Committees on Military Affairs. The Committee strongly felt that the obligations of physicians under the draft does not

extend to government programs which are not primarily organized for the care of military personnel but rather to care for civilian personnel and the dependents of Armed Forces personnel. In addition representation was made to the appropriate parties in Congress that the incentive pay be continued as is currently in effect.

The chief item for consideration by this committee was related to the plan for Medical Services in the overall Civil Defense Plan for North Carolina. A master plan providing for Emergency Medical Service was presented to the House of Delegates at the 1958 Meeting which was adopted by that body and therefore is sufficiently authorized. Written plans have been completed and filed with the State Director of Civil Defense for nineteen different counties. The committee recognized that in the event of an emergency of statewide proportion that great coordination with authority at state and local levels would be required. The State Office of Civil Defense has no current power, but it is understood that North Carolina law provides that the. Governor could assume unusual powers in case of an emergency. There is not an authority at the present time to integrate local and state plans.

The committee urges: (a) that each county hasten to formulate a plan; (b) that it conform in general with the plan written at the state level and with the plans and procedures of the State Office of Civil Defense; (c) to determine the number of county Medical Societies that have a plan and get an actual copy of those plans in the hands of the Medical Director under the state plan (This means that a copy should be sent to Dr. George Paschal, Raleigh, North Carolina.); (d) secure documentation of the disaster plans and a roster of personnel which have been developed by the general medicalsurgical hospitals in the state who conform to the standards of the Joint Council on Hospital Accreditation; (e) that the counties adopt the disaster plans developed by the general medical-surgical hospitals in the community and place these on operational basis and integrate these plans with the Office of Civil Defense plans at the county society level; (f) to bring up-to-date the roster of the personnel participating in these disaster plans as developed by the general medicalsurgical hospital.

The committee also considered the advisability of demonstrating a 200 bed hospital unit which is available from the Office of Civil Defense. At present there are 18 such hospital units stored in different areas of the state. One of these hospitals can be secured, and the committee recommended its demonstration at the forthcoming annual meeting. It further suggested that it be demonstrated in different locations over the state and that the medical personnel needed to the satisfactory operation of such a unit familiarize themselves with the equipment so that, if necessary, these units could be put into actual operation. It is recognized that the operation of a 200 bed hospital unit as well as rendering medical services to the public at large must be coordinated with the Office of Civil Defense at both local and state levels.

Finally, the committee discussed what use could be made of personnel at the three Medical Schools within the state .This matter will be further explored. The committee has no specific recommendation except that it urges all county societies to complete their planning for Emergency Medical Service as quickly as possible.

/s/ George W. Paschal, Jr., M. D. Chairman

COMMITTEE ON SCIENTIFIC EXHIBITS

The Committee on Scientific Exhibits has been very fortunate in obtaining more exhibits for the 1959 meeting from within the State of North Carolina than usual. A total of twenty-six exhibits has been obtained, of which thirteen are being presented by members of the Society.

/s/ Everett I. Bugg, M. D., Chairman R. W. Coonrad, M.D. Harold D. Green, M.D. R. Beverly Raney, M.D.

EYE CARE AND EYE BANK COMMITTEE

During the past year this committee's activities were limited. No formal meeting of the members was held. A glaucoma detection program among industrial workers, to be conducted under the supervision of Dr. Stocker and associates, was approved. Pamphlets entitled "What Is an Ophthalmologist" were distributed to members of the legislature. The committee was not called upon by the Eye Bank during the year.

/s/ H. M. Dalton, M. D., Chairman

FINANCE COMMITTEE

Your Finance Committee has repeatedly investigated and studied the fiscal affairs of the Society and are pleased to report that for the first time in five years we have an excess of income over expenses as of December 31, 1958. The amount exceeds \$9,000.00.

In the auditor's report attached to this report, you will find that Jim Barnes and his staff sold \$64,293.00 in advertisements and exhibit space. This amount is almost double the \$37,370.00 reported in the April 1958 transactions. I point this out to you because I want you to give credit where credit is due for the happy financial state we find

ourselves in this year.
You will remember that the House of Delegates meeting in Asheville last year instructed all committees to keep within their budgeted allowances. Look on exhibit "C," Page 2 of the auditor's report the last column. Those figures in parenthesis represent deficit spending. However, with the exception of the Journal budget, the total allocated to each department, such as Intro-Functional Activities extra-functional activities actually stayed within their budget. I believe a little robbing of Peter to pay Paul is necessary to keep the budget flexible enough to function

You should know that your Society is doing almost a \$200,000.00 a year business, that your total capital assets and bonds amount to approximately \$93,000.00. That your employees have a retirement system and incentive pay raises. That to the best of our knowledge your Headquarters Office is being run efficiently and effectively. That your employees are loyal and happy in their work.

with maximum efficiency.

/s/ Wayne J. Benton, M. D., Chairman

COMMITTEE ON GOLF

We have been informed by the Committee on Golf that arrangements have been made for the men's golf tournament to be played throughout the day of Monday, May 4th, and Tuesday, May 5th, at the Asheville Country Club. The Club management being responsible for recording the scores and making report to Dr. Walter M. Watts, Chairman of the Committee, Doctors Building, Asheville.

Suitable prizes have been arranged by the Headquarters Office to complement this tournament,

Due to prior committments, it was not possible for the Committee to arrange for tournament play on Sunday, May 3rd.

The Committee on Golf is acceptable to the arrangement by which the local arrangements Committee of the Women's Auxiliary has arranged a women's golf tournament at the Biltmore Country Club, Monday, May 4, at 9:00 A.M. Suitable prizes have been arranged by the Headquarters Office to complement this program and any matters related to this tournament can be cleared with

Mrs. John R. Hoskins, III, representing the Auxiliary of the Buncombe County Medical Society, Asheville, N. C.

s Walter M. Watts, M. D. Chairman

COMMITTEE ON MEDICAL SOCIETY HEADQUARTERS FACILITY

The Committee met at the Sir Walter Hotel in Raleigh Sunday morning, February 1, 1959. Dr. Alexander Webb, Jr., of Raleigh presided and a quorum of the committee

was present.

The Chairman reviewed the history of the movement under which such a committee was activated in 1955, headed by Dr. W. M. Coppridge, and the ultimate recommendation that the Society acquire property for a building site on Raleigh-Durham Highway 70; that general authority of the Executive Council to purchase a tract had been given: that a 50-acre tract had been purchased in February 1956 with the use of Reserve Funds: that a tentative style and building sketch of a Georgian structure had been agreed upon by the Committee to be financed at an estimated cost of \$350,000: that a descriptive brochure had been prepared for the Council and the House of Delegates meeting in 1957: that the Committee put a proposal to the Executive Council to be recommended to the House of Delegates indicating the serious congestion in rented headquarters space, the serious effect upon the efficiency of the executive offices by reason of the congestion, certain proposals relative to a special due of \$100.00 per member to be paid over a period of five years and a request for instructions and authority to go forward with the enterprise of building headquarters.

The Committee investigated the record and has information indicating that because one or two small county societies had registered some protest the Executive Council received the report of the 1957 Committee without recommending an action and that the then Chairman, Dr. Hugh Thompson, thus reported to the House of Delegates in 1957 with the result that no action was taken nor the Committee further instructed on the sub-

ject.

The Chairman reported that subsequent to his assuming the Chairmanship, no very marked outline of objective had been given the committee. However, on May 25, 1958 he had called a meeting of the committee to hear a proposition from the Research Triangle presented to the Committee by Mr. George Watts Hill, Sr., of Durham . After hearing this proposition the Committee took

action seriously recommending that the Society consider integrating a headquarters unit in the Triangle either as a leasee of facilities or of obtaining building rights and locating and constructing a building there. However, there was not unanimity on such a proposition and officials of the Society had by then indicated a course of purchasing residential property in Raleigh to activate as a headquarters looking to a long deferred building program on the highway tract.

On the basis of this objective lead the Chairman reported a detailed spot review and inspection of such residential properties apparently available in Raleigh. Most of it was not found satisfactory and one or two structures which were suitable had either not been readily available or had just slipped through sales and exchange and therefore. had become unavailable. He reported a later detailed survey of properties in Raleigh with President Lenox D. Baker, in company with Mr. James Barnes, and reported the possibilities of a \$70,000 purchase of the old Kitchin property on Route 70—Downtown Boulevard -which it was thought could be renovated to give adequate space for 8-10 years and a self-liquidating auto parking area and which prospect would enhance in value due to its adjacent position to State Building expansion and commercial developments along Downtown Boulevard. Dr. Webb further reported the views expressed by President Baker on June 2, 1958 when he wrote a member of the Society:

"I have no firm opinions. My ideas are as follows: (1) The Medical Society Headquarters should be as near the center of the political activities in Raleigh as possible; (2) The Society should have adequate space for offices and it should be furnished in a manner in keeping with the profession represented; (3) We should take definite steps toward developing a site for such headquarters with ample room for (a) the North Carolina Hospital Association, (b) the North Carolina Nursing Association, (c) the North Carolina Pharmaceutical Association, (d) the North Carolina Dental Association and (e) other organizations interested in health affairs of the people. This would facilitate joint use of some productive facilities for economy purposes to all concerned."

It was reported that letters were directed to 28 health organiations inquiring of their interest in a joint-use facility on a rental basis or otherwise. Only two agencies responded a positive interest and the great majority responded to indicate other existing facilities or alternate plans for housing their

headquarters. Thus, a joint enterprise for a headquarters facility seemed out of the range of interest on the part of the health agencies queried.

Dr. Webb reported the present hearquarters occupied 2088 sq. feet of space, one-third of which was gross storage and not suitable for productive occupancy and that this space cost the Society a total of \$4,074.00 per year. Moreover, that any replacing rental space would cost approximately twice what is now

paid annually for rent.

After a thorough discussion the committee took action to express the sense that the Society should not consider the purchase of obsolete rehabilitable property in the City of Raleigh and by formal action so recommends to the Executive Council and the House of Delegates. By further formal action, the committee advised a restudy of the proposal to build upon the site of acreage along Highway 70 and that the committee explore the construction of a modern-efficiency type of building rather than a more artful structure. To this end it formally took action to:

1. Recommend building on the Highway 70 tract.

The Chairman and Executive Director visit and study modern types of headquarters building in other states.

3. That a sub-committee be authorized to undertake an educative program directed to the membership involving the necessity for a headquarters and the economy involved in the location of the building either in the City of Raleigh or on the Durham highway.

/s/ Alexander Webb, Jr., M. D.,

Chairman Graham B. Barefoot, M. D. Newsom P. Battle, M. D. Harry L. Brockmann, M. D. Wm. M. Coppridge, M. D. Elias S. Faison, M. D. Charles I. Harris, M. D. Isaac E. Harris, Jr., M. D. Frederick C. Hubbard, M. D. Wm. A. Hoggard, Jr., M. D. Wm. P. Kavanaugh, M. D. W. Walton Kitchin, M. D. Donald B. Koonce, M. D. Ross S. McElwee, Jr., M. D. Hunter McG. Sweaney, M. D. Robert M. McMillan, M. D. Malory A. Pittman, M. D. James Kent Rhodes, M. D. A. Hewitt Rose, Jr., M. D. James P. Rousseau, M. D. O. Norris Smith, M. D. Warner L. Wells, M. D. Thad B. Wester, M. D.

COMMITTEE ON HOSPITAL AND PROFESSIONAL RELATIONS AND LIAISON TO NORTH CAROLINA HOSPITAL ASSOCIATION

The Committee on Hospital and Professional Relations met at Sir Walter Hotel, Raleigh, North Carolina, Sunday, January 4, 1959, on purely Medical Society matters.

Several problems had arisen in various hospitals concerning relations between hospitals and the professional staff. These were as follows:

ITEM I:

The Professional staff of the Columbus County Hospital had a difference of opinion with the governing board of the hospital concerning physician's charges to so-called Welfare patients. It was the sense of the Medical Staff of the Columbus County Hospital that they were better able to evaluate the ability of their patients to pay in relation to their financial situation than the hospital governing board and it was their thought that some patients admitted to the hospital as welfare patients could, in fact, well afford to pay a professional fee. It was the feeling of this Committee that patients requiring hospitalization carried on the Welfare roll should receive no bill for professional service, and the Columbus County Medical Staff was so informed. This difference of opinion between governing board and professional staff was resolved amicably by these two groups by arriving at the conclusion that the physician be permitted to bill those patients he thought able to pay.

This inquiry brought to light, after discussion, the lack of any uniform manner of handling the professional account of the borderline medically indigent patient throughout the entire state. It was proposed, duly seconded and passed that this Committee try to frame a survey questionnaire to be circulated to each County Medical Society for the purpose of obtaining information as to how each individual county handles welfare payments in their respective localities. This questionnaire is being formulated at this time.

ITEM II:

An inquiry from the Annie Penn Memorial Hospital, Inc., Professional staff in Reidsville, N. C., was received pertaining to the interpretation of electrocardiograms. It was the opinion of this committee that non-qualified men should not attempt to interpret electrocardiograms but that this should be done by men who have had special training in this field. This opinion is substantiated by the Joint Commission on Hospital Accreditation. This question was resolved by the

Professional Staff of the Annie Penn Memorial Hospital in such a manner that qualified cardiologist were appointed as interpreters for electrocardiograms done in their hospital.

ITEM III:

A resolution from the Maryland Medical Society was received regarding hospital accreditation recommending that accreditation requirements should be adjusted to local situations so long as the level of patient care was not lowered. This Committee recommended to the Executive Council that it concurs in the Maryland resolution so long as no downgrading of hospital or medical care resulted.

ITEM IV:

This Committee received from the Rowan Davie County Medical Society a request that we investigate a dispute at the Davie County Hospital, Mocksville, N. C., and act as a referee in the matter. After much correspondence and telephone conversations the Chairman of this Committee met with the Medical Staff of the Davie County Hospital, the Chairman of the Board of Trustees and the Administrator. The controversy between the Professional staff and the Board of Trustees of this hospital at one time reached the point where the entire Professional staff resigned their privileges at this hospital. Major problems involved in this dispute seemed to center around the allotment of privileges both surgical and non-surgical by the Board of Trustees and the many marked restrictions of a rather haphazard nature imposed upon the Professional staff by the Board of Trustees. It was the contention of the Chairman of the Board of Trustees that the Professional staff had already proven itself unwilling and/or unable to police its own professional practices within the hospital and that it therefore became necessary for the Board of Trustees to take over in these matters. After reviewing the rules, regulations and by-laws as adopted by the hospital Board of Trustees it was obvious to this Committee that these were totally unrealistic and should not be imposed upon the Professional staff of this hospital. After talking with this Professional staff it also became quite obvious that the members of the Professional staff were not adhering to the rules, regulations and by-laws which they themselves had drawn up and adopted. Consequently, it was the objective opinion of this Committee that both the Professional staff and the Board of Trustees were at fault and it was proposed that a sub-committee of the Professional and Hospital Relations Committee be appointed to meet with the Medical

staff and Board of Trustees of the Davie County Hospital to aid them in developing a skeleton set of by-laws, rules and regulations for the conduct of the Professional staff. It was decided that this sub-committee would become active only if the Professional staff and the Board of Trustees of the Davie County Hospital should want our help and advice. A communication received from Dr. Ralph Gambrell, a member of the Professional staff of the Davie County Hospital, indicated that it was the combined feeling of that Hospital Professional staff that their problems would resolve themselves. There apparently has been no conflict between Professional staff and Hospital administration since investigation of the matter by the Chairman of this Committee.

ITEM V:

Two additional problems which, as yet, are incomplete have been placed before this Committee. The first involves an appeal by a member of this Medical Society for help in regaining certain types of operating privileges which have recently been denied him in the hospitals in his City. This problem has not been brought to the full Committee but it was the feeling of the Chairman of this Committee that this is a local problem and one which the various hospitals and Professional staffs are more able to judge than this Committee. A second problem now under consideration by this Committee concerns the control of medication given to an outpatient in the emergency room of a hospital. A hospital Administrator in this State has recently ruled that "no doctor can give his own medications to an outpatient and that all drugs given in the emergency room must be owned and administered by hospital personnel." It seems to be the feeling of the Professional staff of the hospital concerned that this constitutes encroachment on the freedom that should exist in the doctor-patient relationship and as such may constitute third party intervention.

The second meeting of the Committee on Hospital and Professional Relations in Liaison to the North Carolina Hospital Association was held 27th January, 1959, at the Carolina Hotel, Raleigh, North Carolina, Although adequate preparations had been made for this meeting and after concessions by the Medical Society Group had been made to the Hospital Association Group as to the date of the meeting the only representatives available for the meeting were those from the State Medical Society. The only representation at this meeting from the Hospital Association was an ex-officio member, Mr. Marion Foster, Executive Secretary of the

N. C. Hospital Association. Due to the obvious fact that no members from the N. C. Hospital Association were present no "Liaison" was accomplished.

/s/ Theodore H. Mees, M.D.,

Chairman
Grover C. Bolin, Jr., M.D.
Arthur H. London, Jr., M.D.
F. M. Simmons Patterson, M.D.
William H. Pettus, Jr., M.D.
James S. Raper, M.D.
C. F. Siewers, M.D.
J. O. Williams, M.D.
George T. Wood, Jr., M.D.

COMMITTEE TO WORK WITH INDUSTRIAL COMMISSION OF NORTH CAROLINA

The Committee of the North Carolina State Medical Society to Work with the Industrial Commission has continued to meet semi-annually. The number of cases with fees which have been contested and heard by the Medical Advisory Committee has gotten progressively less. The work with the Commission has generally been harmonious

and we feel mutually beneficial.

The Commission and the medical director have agreed to routinely submit a note of explanation to physicians whose bills have been cut, except in those cases where the physician has disregarded the fee schedule approved by the Commission. It is felt that the note of explanation which now accompanies all cuts of unlisted fees has been a great help to the physicians in knowing how they should make out their charges, and also to the Commission in cutting down on their paper work. The Commission and the medical director have shown consideration for unusual cases, both in the executive category and with the medical complications when they have been informed of such by explanations from the attending physicians.

There are two new bills being introduced to the Legislature this time which have been

considered by our Committee:

(1) SB 53—The Committee feels that this bill would encourage patients shopping around to seek higher ratings for their disability. The Commission gave us some background on this bill and informed us of attempts which are being made by lawyers to send their patients across the state and to other states to individuals who are known to give higher ratings. The Committee feels that this Legislation would not be beneficial to the administering of the Act and opposes it.

(2) Bill to be introduced but not yet named

— This bill would put all city
and county officials, elected and
otherwise, under Workmen's
Compensation. This bill is designed to increase the wedge of
individuals who are covered under this Act. It is regrettable indeed that the Medical Society
did not oppose similar legislation to include executives when
this addition was added to the
Act in 1955 and 1957. We
strongly advise that the Society

actively oppose such legislation.

It was the recommendation of the Committee that a proposed rating guide for disabilities of the upper extremities and lower extremities which has been worked out by the North Carolina Orthopaedic Society and tentatively approved by the Commission, be endorsed and incorporated with the published fee schedule along with the guide for the rating of backs.

It was the recommendation of the Committee that some alteration in the award for amputations of the upper and lower extremities be made. As our industry has become more mechanized there has been an increasing importance on the upper extremity: Therefore, it is recommended that a relative increase in value of the upper extremity to the lower extremity be made.

Our Committee discussed at some length the inclusion of executives under Workmen's Compensation with the entire Commission. As the Commission's job is to carry out the functions of the Act, their duties are clearcut now that this has become law. There is facility for special consideration of care given to company officials. The physicians should send a note of explanation along with their forms #25, informing the Commission of the executive status and special considerations necessary for the patient involved.

The matter of third party liability cases which were also covered under Workmen's Compensation has been discussed in great detail with the entire Commission. An official ruling from the Attorney General will be obtained from the Commission as to whether or not a physician may submit additional charges to a patient who was treated under Workmen's Compensation and had his fee regulated accordingly, who later becomes liability and is awarded a large sum of money. It is the opinion of all that the physician should be allowed his usual full fee under such circumstances. The mechanism of having this done, however, is not clearly understood. If the Attorney General returns

an adverse opinion, as expected, it will require an Act of the Legislature to have this altered.

The Advisory Committee's functions with the Commission have recently been harmonious and we feel have helped give the Commission a better understanding of the problems, principles and intentions of the physicians of our State.

s Thomas B. Dameron, M.D., Chairman William F. Hollister, M.D. James S. Mitchener, Jr., M.D. Guy L. Odom, M.D. Malory A. Pittman, M.D. C. T. Wilkinson, M.D.

INSURANCE COMMITTEE

The Committee on Insurances met September 17 in Raleigh with the majority of the members present. This meeting consisted of conferences with the secretary of the St. Paul Companies who presented an outline of the liability program which the Society was endorsing in cooperation with this company. The outcome of this meeting was a reduction in the premiums charged members to the State Society and a review of the whole program. The experience to date seemed good and your committee plans to meet again with the representatives of the company sometime in the Spring of 1959 to re-evaluate the whole plan.

An additional conference was held with Mr. J. L. Crumpton, the Administrator of the disability program endorsed by the State Society. Experience with this policy has been excellent and it was the committee's feeling that it was operating as well as we could expect. At a recent conference with Mr. Crumpton in Durham in March 1959, a tentative proposal was presented to the chairman of your committee of a plan which his company hopes to offer the State Society for its consideration in the next three to four months.

Conferences were also held with Mr. Golden of Durham who discussed the group professional overhead expense program and also the catastropic hospitalization program both of which are sponsored by the Medical Society of the State of North Carolina. Reception of both of these programs has been satisfactory and your committee feels that these are the best policies that can be obtained for the Society at the present time.

Problem of group life insurance was discussed but no definite action was taken.

Subsequent to this meeting in September, correspondence has been received from Dr. Lenox Baker and Dr. B. F. Hawkins of

Concord, North Carolina, relative to activities of the insurance committee in the future. Both of the gentlemen are of the feeling that the State Society should take an active part in acquainting the general public in North Carolina as to what should be expected from health insurance. The chairman is in complete agreement with this and I would like to recommend that this be high on the agenda for consideration of the insurance committee during the next year.
s Joseph W. Hooper, M. D.

Chairman

COMMITTEE ON LEGISLATION

Submitted herewith is a report of the Legislative Committee action to the present time.

The committee has held only on formal meeting, that being on the 9th of November 1958. All members of the committee were present, and in addition, we were privileged to have Dr. Beddingfield, the Commissioner, Dr. Lenox Baker, President, Dr. John Rhodes, Secretary of the Medical Society of the State of N. C. In addition, Mr. John Anderson, Mr. James Barnes, and Senator David Rose, Representative Rachel Davis, Dr. Joseph Combs, Secretary of the Medical Board of Licensure. Dr. Rousseau, a member of the American Medical Association Committee on Legislation, Dr. Street Brewer, Dr. John R. Kernodle, Dr. Robert Proctor, Dr. Edward U. Austin, Chairman of the Legislative Committee of the N. C. State Dental Society and Dr. John Hamilton representing the N. C. State Board of Health.

On the agenda and discussed were the following:

 Dr. Rousseau discussed prospective federal legislation relative to a Forand type bill and to a Simpson-Keogh Bill, These two bills were further discussed by those present.

Dr. Street Brewer made a report from the Medical Care Commission, and the committee approved the recommendations of the Medical Care Commission relative to hospitals and public welfare.

- Dr. John Kernodle, Chairman of the Committee on Chronic Illnesses, presented some of the matters relative to construction of chronic disease wings on hospitals and also public welfare support to the indigent. It was the feeling of Dr. Kernodle and his committee that the chronic disease wings on general hospitals would be a concrete proposal in deference to a Forand type bill.
- Dr. Ravenel and Mr. John Anderson presented the compulsory Poliomyelitis

Bill which was to have been, and in fact was, introduced in the General Assembly in 1959. It is of note that this bill has already had a hearing and there is excellent prospect of its passing.

- Dr. James Proctor, representing the section on psychiatry, presented a bill recommending that the Legislative Committee have it presented to the General Assembly in 1959, having to do with crimes against nature. It was the feeling of the committee that this was not a matter that directly concerned the Medical Society, therefore the matter was tabled.
- The North Carolina Hospital Association presented several legislative matters which the committee agreed to endorse subject to the approval of the Executive Council. These were: Assistance to schools of nursing; compulsory automobile liability insurance covering hospital and medical care; elimination of intra-county residency law for welfare assistance; pool hospital fund; Medical Care Commission appropriation request for hospitalization, raising the appropriation from \$1.50 to \$2.50 per day; and a request from the Medical Care Commission for \$1,000,000 in state funds for additional hospital construction.

Dr. Joseph Combs reviewed the Medical 7. Practice Act and anticipated no re-open-

ing of that Act.

A bill from the Highway Patrol rela-8. tive to mandatory blood test for alcohol and those suspected of driving drunk was presented and received the endorsement of the committee. It is the understanding of the committee that this bill will be introduced and sponsored by the Highway Patrol with the endorsement of the Medical Society.

There was considerable discussion relative to statute permitting therapeutic abortion on fetal indications. This matter was discussed by the obstetricians and pediatricians who were present. The matter is, at this time, under advisement by the section of obstetrics and gynecology, and no action is antici-

pated at this time.

Another bill which the State Bureau 10. of Investigation and Highway Patrol is interested, has to do with the limiting of license to individuals under the influence of certain drugs. This matter, again, received the endorsement of the committee, but it is to be presented to the Legislature by the Highway Patrol. 11. A question of the Lye Bill was again discussed and it was thought it was not necessarily a bill for the Legislative Committee to consider.

12. There was consideration of the laws in North Carolina relative to voluntary steriliation. At this time, there are no laws on the statute books other than the old law of Mayhem. This matter was discussed but was tabled for the time being.

Dr. Edward U. Austin, Chairman of the Legislative Committee of the State Dental Society, presented the problems of the dentists in regard to collecting fees from various voluntary insurance companies, particularly the Blue Cross Hospitalization Company. This matter was referred to the Committee on Insurance of the State Medical Society for their collaboration.

There were further discussions relative to Bills which the Medical Society would obviously want to oppose when they present themselves in the Legislature. The exact nature of these bills is undetermined; most of them had to do with the optometrists and chiropodists proposals and the committee was unanimous in its feeling that the bills increasing the scope of the practice of these two groups should be limited.

Mr. Anderson discussed the discriminatory taxes on physicians, which have been considered in the past, and obviously the Society

shall oppose.

By way of summary then, the Legislative Committee, with the approval of the Executive Council and House of Delegates of the Medical Society of the State of N. C., has agreed to have introduced and actively support a bill for compulsory poliomyelitis vaccine. It will lend its weight and support to certain legislation developed and devised by the Highway Patrol and other law enforcement agencies relative to blood tests for alcohol and those suspected of driving drunk as well as limitation of license to those known to be various drug addicts. support is also anticipated from the Medical Care Commission and the N. C. Hospital Association and the N. C. Association of Nurses relative to subsidizing schools of nursing and making available scholarships for nurses to receive training.

Submitted herewith then is the report of the Legislative Committee of the State of N. C.

> /s/ Hubert McN. Poteat, Jr., M.D., Chairman Sam D. McPherson, Jr., M.D. Joseph S. Holbrook, M.D.

Lenox D. Baker, M.D. John S. Rhodes, M.D. Jesse Caldwell, Jr., M.D. H. Fleming Fuller, M.D. Donald B. Koonce, M.D. Leslie M. Morris, M.D. S. F. Ravenel, M.D. Ben F. Royal, M.D.

SUPPLEMENTARY REPORT TO THE COMMITTEE ON LEGISLATION

Since our original meeting in January, for the purpose of discussing legislative matters, a number of items have come through our office, and we have been able to deal with them, I think, satisfactorily, and I thought it might be well to advise each of you of some of the things which have transpired. May I suggest that if you have any comments adversely or otherwise concerning the actions which have been taken, and those which we propose to take on the matters which follow, please let me know, or if it is more convenient communicate directly with Mr. Barnes.

1. The Poliomyelitis Bill was introduced, and the Medical Society was represented at the public hearing, and made representation to the committees at that time. You will be interested to know that both the House and Senate Committees approved the bill, and it has passed the Senate and is now in the House and there is every reason to believe that it will be passed very shortly. Dr. Ravenel and his committee are to be highly commended for the excellent manner in which this Bill was prepared and presented.

2. The Blood-Alcohol Bill has been prepared, and I have seen the copy thereof. There is to be an open hearing on the Bill before the Joint Committees of the House and the Senate on the 25th of March, and organied medicine will be represented at that time. The Bill, as it now stands, provides roughly that the blood, saliva, urine, or breath may be used as a source of material for doing the alcohol determination. This bill, as you know, is sponsored by the Highway Patrol and we are lending our support thereto.

3. The Nursing Bill; this has been a source of considerable difficulty and confusion to us. Dr. Brockmann, who is Chairman of the State Society's Committee on nurses, and I attended a conference of the hospital administrators and the nursing association officials in Raleigh, and it appeared then that the Bill which should be introduced, would be co-sponsored by the hospital administrators' association and by the nursing association. As it was finally prepared, the

bill provides for \$200,000 annually for nurse scholarships and \$200,000 annually subsidiation for schools of nursing in North Carolina. I do not believe that this bill stands much chance of getting through. I can't believe that the Legislature will put that much money into a subsidiation bill of this sort. However, we are still working on it and it is possible that it may be changed to some degree before it finally reaches the House and the Senate for a vote.

Along the line of this nursing bill, there has been another bill introduced in the Congress proposing to subsidize nurses on a federal level. The State Society has made representation to our Congressmen requesting that they oppose this bill, in view of the fact that we are undertaking to handle the same situation locally.

There has been a Commission set up in the recommended changes made by the Commission for reorganization of the State Government relative to the management and handling of radio-active material, including x-ray, diagnostic and therapeutic machines. We have had a considerable amount of difficulty with the Commission which drew up the preliminary recommendation to the degree that they had not included any physicians, dentists, or physicists, on the committee which will act in an advisory capacity to the State Board of Health. This matter was handled by Dr. Baker and correction has now been made in the proposed bill which we feel is satisfactory.

5. Another bill having to do with water resources in North Carolina, removes from the State Board of Health some of the degree of control it had over drinking water. This bill is still in the formative stage, and it is the opinion of some of us that organied medicine should oppose the changes unless and until the State Board of Health is given adequate assurance of its role in the maintenance of pure water supply for the consumption of human beings.

6. Another bill has been introduced by Dr. Rachel Davis, having to do with the sterilization of women who are found "grossly sexually delinquent." As I understand it, this bill would provide that any woman who gave birth to 3 or more illegitimate children would be sterilized, and thereby reduce the cost to the Welfare Department of supporting these illegitimate children. The bill has been introduced in both the House and the Senate. As you will recall, this matter was discussed at our meeting in January and it was tabled with no action being taken. The Section on Obstetrics and Gynecology was going to make a study and report to us at a later date.

It is my understanding that this study has not been completed and it is further my opinion that organized medicine in this state should not participate in the sponsoring of

However, it is also my feeling that if any physician wishes to express himself from a personal point of view, he should be entirely at liberty to do so. So far as the Legislative Committee is concerned, I have no instructions from the Committee or from the Executive Council or from the House of Delegates, and therefore no representation will be made

from the Medical Society.

The Osteopaths have a bill which has not been introduced, and which has not been seen in its entirety as yet, having to do with increasing the requirements for man to take the osteopath board in North Carolina. This is going to be a difficult bill for us to oppose, however, we are obviously going to have to make some representation in opposition thereto. At such time as we are able to see the bill and study it and have a conference with our attorney in the matter, I will try to let you know.

Copies of Dr. Baker's address to the Conference in Pinehurst in regard to doctors participating in political affairs have been mailed to all members of the Congress, and all members of the State Legislature and a great many acknowledgments have been received.

I believe that these are the high spots of our activity since our meeting in January. I will appreciate any comments from any one of you and assure you that I have had the greatest of help from Mr. James Barnes, Mr. John Anderson and from Dr. Lenox Baker in undertaking to manage these affairs. I really don't see that there is much point in our having another meeting of the Legislative Committee, however, if it is desirable by any, if you'd be good enough to let me know I certainly will undertake to arrange it. I am at your disposal and would solicit and appreciate any comments or ideas you have relative to the above mentioned matters.

/s' Hubert M. Poteat, Jr., M. D.

Chairman

COMMITTEE ON MATERNAL HEALTH

Table I lists the birth rates, livebirths, maternal deaths and maternal mortality rate in North Carolina for the years 1949 through 1958. The figures for 1958 are provisional. The others are now final.

Table 1	TO 1.1		Madaumal	Maternal Mortality
	Birth		Maternal	
	Rate	Livebirths	Deaths	Rate
1949	27.0	107,970	127	11.8
1950	26.2	106,486	126	11.8
1951	26.9	110,910	123	11.1
1952	26.7	111,272	113	10.2
1953	26.5	111,856	109	9.7
1954	26.9	114,846	91	7.9
1955	26.7	115,365	96	8.3
1956	26.5	115,792	78	6.7
1957	25.6	113,143	81	7.2
1958*	24.9	111,280	60	5.4

Provisional. Source: National Office of Vital Statistics, USPHS, Section on Vital Statistics, North Carolina State Board of Health.

The table indicates that during the past 10 years the number of livebirths occurring in the state rose gradually to a maximum in 1956 of nearly 116,000. Since 1956 there has been a rather precipitous drop in the number of deliveries and the provisional rates for 1958 indicate that the number of deliveries will be 110,000 to 112,000. The effect of the rising population of North Carolina is offset to some extent by a diminishing birth rate. This drop in the birth rate and number of deliveries is not expected to continue. A reverse trend should occur. During the past year the maternal deaths from the inception of the Committee until the present time were analyzed and some of the pertinent data are herein presented.

Date of Case No.1 - July 13, 1946 Date of Case No. 1000 - December 23, 1950 Date of Case No. 1001 - December 31, 1950 Date of Case No. 1959 - February 29, 1956

Table 2

		ARY CAUSI	E OF DE.	HTA		
	Gro	up = 1	Gro	up ±2	7	Cotal
Toxemia	264	26.4%	264	27.6%	528	27.0%
Hemorrhage	259	25.9%	226	23.67	485	24.7%
Embolism	74	7.4%	87	9.1 %	161	8.2%
Infection	73	7.3%	52	5.4%	125	6.4%
Cardiae	46	4.67	25	2.6%	71	3.6%
Anesthesia	25	2.5%	28	2.9%	53	2.7%
Other Obstetric	103	10.3%	94	9.8%	197	10.0%
Nonobstetric	113	11.3%	148	15.5%	261	13.3 %
Indeterminate	333	3.3%	35	3.6%	68	3.4%
Obstetric	844	84.4%	776	81.07	1620	83.3%
Nonobstetric	113	11.3%	148	15.47	261	13.3%
Indeterminate	33	3.3°_{c}	35	3.6%	68	3.3%

This represents the primary cause of death and the cases received by the Committee. (Although 2,000 cases were completed the 1959 herein recorded were on a similar type of IBM cards and the remaining 40 were on a new form and for ease of recording are not included.) In essence the two leading causes of maternal mortality remain the same in the designated periods. Toxemia continues to be the leading cause of maternal mortality with hemorrhage a close second. Infection continues to drop as a cause of maternal mortality, the number of cases in which information was inconclusive remains at the level of 314 per cent.

The examination of maternal deaths by race indicated that maternal deaths are concentrated in the nonwhite segment of the population. Table 3 indicates that the maternal deaths in the nonwhite groups has risen from 58 per cent to 66 per cent. There has been a slight decrease in the percentage of matern? I deaths associated with the unmarried status.

Table 3

	RACE AND LEGITIMA	ACY	
White	41.5 %	33.5 ℃	37.0%
Nonwhite	58.5 ⁻ 7	66.5 %	63.0%
Legitimate	83.0 %	85.0%	84.0%
Illegitimate	17.0%	15.0%	16.0%

Prenatal care in the women who died in association with pregnancy still indicates that a very large percentage of them do not receive any prenatal care or such prenatal care is inadequate. Table 4 indicates some slight improvement in this respect. Of the 1959 women who were studied 80 per cent received inadequate or no prenatal care and one-third of them received no prenatal care at all.

Tablt 4

	PRENATAL	. CARE	
Ideal	3 - 0.2%	1 -	4 - 0.4%
Adequate	161 - 19.1%	163 - 21.0%	324 - 20.0%
lnadequate	358 - 42.5 %	340 - 44.0%	698 - 43.0%
None	319 - 38.0%	270 - 35.0%	589 - 36.4%
Unknown	3 - 0.2%	0	3 - 0.2%
Total	844 -100 €	774 -100 %	1618 -100 %

In reviewing the age and parity it is interesting to note that 19 per cent of the maternal deaths were in women over para viii and 13 per cent in women over para x. Age range indicated an inordinately high incidence of maternal deaths in the older age groups. The preventable factors were numerous but it was a happy note that the percentage of preventable cases dropped from 90.9 per cent in the first 1000 to 86.9 per cent in the second thousand. This drop has been noted by other committees and can be expected to continue as the physicians eliminate various preventable factors.

In examining the causes of maternal mortality in detail it is noted that although the relative proportion of toxemia increased, increased of eclampsia dropped, the incidence of both preeclampsia and hypertensive cardiovascular disease did increase. In the maternal deaths

due to hemorrhage an increase was noted in the number of ectopic deaths, deaths due to premature separation of the placenta, and to rupture of the uterus. The problem of rupture of the uterus is certainly a preventable one and appears to be an unnecessary increase. The exact cause of this is not clear. Reduction was noted in connection with placenta previa and in postpartum hemorrhage. The number of patients who died from hemorrhage and failed to receive any blood continues to be high, being approximately two-thirds of the entire group. Midwives were found to be responsible for 6½ per cent of maternal deaths while delivering roughly 8 per cent of the total patients in the state. This indicates that the midwives are still delivering patients without selection. It should be emphasized that although some progress has been made, particularly in the total reduction of maternal mortality, many of the same problems still exist and much can still be done with the facilities already at hand to further reduce the problem of maternal deaths. Students of the problem of maternal mortality are in agreement that although the overall rates are dropping essentially the same problems exist. Furthermore, in spite of the rather marked improvement in maternal mortality, the other measure of maternity care, perinatal mortality, has not dropped at the same rate. Obstetricians consider that perinatal mortality is a more delicate measure of the amount and quality of obstetric care rendered.

Table 5

MATERNAL MORTALITY 1958

Cause					
Hemorrhage	26	20.0%			
Toxemia	33	25.4%			
Infection	6	$\boldsymbol{4.6\%}$	White	37	28.5%
Cardiac	2	1.5%	Indian)		
Embolism	3	2.3%	Colored)	93	71.5%
Anesthesia	3	2.3%			
Other obstetric	20	15.4%			
Nonobstetric	• 21	16.0%			
Not completed	16	12.4%			
Total	130			130	

One hundred thirty maternal deaths were recorded in contrast to the 60 reported by the Section on Vital Statistics. This difference can be attributed to the inclusion of 21 non-obstetric deaths plus certain deaths included under other categories such as chronic hypertensive disease. It will be noted that the percentages are similar and will probably be even closer to the previous figures when the incompleted cases are completed.

The Committee reports two meetings, the first being July 27, 1958, in Asheville. A number of items were discussed at this meeting, one of which deserves particular attention. Dr. John Burwell, Jr., of Greensboro, who is chairman of a committee of the North Carolina Obstetrical and Gynecological Society to consider the problem of legalizing sterilization, outlined the purposes and functions of his committee. He stated that aside from the Eugenics Law there was no legal definition for sterilization, either for medical or nonmedical reasons. Dr. Burwell on his committee has contacted a number of interested groups concerning this. There was considerable discussion of the problem of legalizing sterilization for medical and social indications aside from those concerned with eugenics or the problem of illegitimacy. The committee felt that control of sterilization by organized medicine including the component county medical societies, the Committee on Maternal Welfare and the North Carolina Obstetrical and Gynecological Society would be a preferable method of control to the ever possible threat of legal action against the physician performing such a procedure. No official proposal was made by Dr. Burwell in view of the fact that the North Carolina Obstetrical and Gynecological Society has not yet had a report from his committee and therefore has taken no official action on it. The Committee stated that any records would be made available in reference to the problem which Dr. Burwell's committee desired and would assist in the activities of Dr. Burwell's committee in every possible way. Further action on the problem was deferred until an official report from the North Carolina Obstetrical and Gynecological Society was made.

The second meeting reported by the Committee was held on February 15, 1959, at Chapel Hill, North Carolina. At this meeting in addition to the Committee, invited guests included Dr. Nicholson J. Eastman, Professor of Obstetrics of Johns Hopkins University, Baltimore,

Dr. Madeleine Morcy and Dr. Eleanor Hunt of the Children's Bureau, Dr. Angus McBryde, Chairman of Committee on Child Health, and others. The primary purpose of this meeting was to discuss the effects of the predicted increase in the obstetric load within the next 10 to 15 years. Currently in the United States there are slightly over four million deliveries a year. It is expected to reach six million by 1970. The obstetric situation was surveyed for the state. The predicted obstetric load in the future for North Carolina was prepared by Mr. C. R. Council, Chief of the Section on Vital Statistics of the State Board of Health and is presented in table 6. This is based on three different birth rate levels into a high, medium, and low.

Table 6

ESTIMATED LIVE BIRTHS BY RACE: NORTH CAROLINA, 1960, 1970

	birth Rate Per 1,00	00 Pop.	
	High	Average	Low
Race	(1954)	(1950-1957)	(1957)
Total	26.9	26.5	25.6
White	24.3	23.9	22.9
Nonwhite	34.4	34.0	33.4

		Estimated Nu	mber Births		
High	Average	Low	High	Average	Low
122,785	120,959	116.851	135.974	133.952	129,403
82,839	81,475	78,066	92.935	91.405	87.581
39,749	39,287	38.594	42,323	41,831	41.093

The summary of the number of deliveries according to the size of practice and the type of practice in North Carolina in 1958 is depicted in table 7.

Table 7

	DISTRIBU	TION OF	DELIVE	ERIES BY	SIZE	AND TYPE	OF	PRACTI	CE
	0	1	6	5	2	3&4	7	8&9	TOTAL
0-10		34.915		1796	131	4 2428	908	570	43,211
	$\tilde{\epsilon}$ 1.3	80.8		4.2	3.	0 = 5.6	2.1	1.3	100.0
101-20		17,196		872	281	4 - 6640	1324	136	30,124
	$\tilde{\epsilon}$ 3.8	57.0		2.9	9.		4.0	.5	100.0
201-30		4,926		232	1703	8 - 5574	942	0	14,138
	$\tilde{\epsilon}$ 3.7	34.7		1.6	12.	1 39.4	6.7	0	100.0
301 plu		322		0	5098	8 2404	340	0	10,746
	20.8	3.0		0	47.3	3 22.4	3.2	0	100.0
Total	4450	57,359		2900	10,93	4 17,046	3514	706	98,219
•	5.0	58.4	1.3	3.0	11.	1 17.3	3.6	0.7	100.0

On the basis of these data the average number of deliveries performed by type of practice was computed and is presented in table 8.

Table 8

AVERAGE NUMBER OF DELIVERIES PER PHYSICIAN ACCORDING TO TYPE OF PRACTICE

	Total Deliveries	Physicians
0—House Officer (Intern or Resident)	4,450	41
1—General Practitioner	57,359	1059
6—Other Specialty	1,310	30
5—Surgeon	2,900	122
1, 6 and 5 with more than 30 deliveries	59.053	1117)
2—Obstetrician - nonBoard	10.934	64
3 & 4—Obstetrician - Board and		~ -
Board qualified	17.046	110
7—Military	3.514	32
8 & 9—Health Officer, USPHS		02
and Physicians not listed		
as licensed in N. C., June,		
1958	706	31
Total	00.010	1489

Following the presentation of these and other data, discussion was opened by Dr. Eastman who pointed out that this anticipated obstetric load would demand more and more time of the physicians in view of the fact that there will also apparently be less physicians per unit of population; that the job of rendering adequate obstetric care would become increasingly difficult. His suggestion, therefore, included the training of obstetric assistants who would be registered nurses with particularly developed ability for assisting the physicians with prenatal care and in the conduct of the first stage of labor. Present kinds of such plans were discussed at length. The Committee as a group felt that better trained paramedical assistants certainly was part of the answer. It was further felt that better training in obstetrics, both for the geenral practitioner as well as the specialist was indicated and a measure should be instituted to attract more people to this field. The meeting was not intended to produce any particular solution of the problem but rather to air some of the problems associated with it.

Dr. Charles Pace, a member of the Committee, offered the following written suggestions after the meeting:

 Form a continuing body to consider this problem if deemed beyond the province of the present committee.

2. Acquaint all of the county societies with this question.

3. Start in the hospitals throughout the state the program of training obstetric assistants.

4. Take steps to correct the general shortage of nurses.

This will be the subject of further discussion on the part of the Committee with the hope of providing recommendations of a specific nature to meet these anticipated needs.

The Committee on Maternal Welfare presented material from their files in th following programs:

SPEAKING: March 18, 1958, "Perinatal Mortality"—Academy of Public Health, Raleigh	Dr. Donnelly
May 30, 1958, "Maternal Mortality—1959 Consecutive Cases," Duke University, Durham	Dr. Donnelly
August 1, 1958, "Causes of Perinatal Mortality," Southern Pediatric Seminar, Saluda	Dr. Donnelly
August 2, 1958, "Maternal Mortality in North Carolina," Southern Pediatric Seminar, Saluda	Dr. Donnelly
	Dr. Donnelly
October 17, 1958, "North Carolina Fetal and Neonatal Mortality Study," New Jersey Travel Club, Chapel Hill	Dr. Donnelly
November 21, 1958, "Nutrition in Pregnancy," Rural Health Course, Raleigh	Dr. Donnelly
November 25, 1958, "Iron Metabolism in Pregnancy," North Carolina Dietetic Association, Greensboro	Dr. Donnelly
70°0' - fall	

The financial report for the year 1958 is as follows:

Receipts	Disbursements
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Medical Society of North Carolina \$3998.16*

Salary - secretary	\$2,400.00
Social Security Tax	54.00
Postage	55.03
Stationery	35.35
Reprints	21.45
Maintenance on Audiograph	20.00
Prints, slides, photos	
Telephone calls	
Typewriter Ribbons	
Tabulation of data	
Travel Expense	
Miscellaneous Supplies	

Equipment 381.85 50.00

Total Expenses \$3,306.26 Overdraft 12-31-57 560.26 \$3.866.48 Balance 1-1-59 131.68

\$3,998.16

s James F. Donnelly, M. D.,
Chairman
Glenn E. Best, M.D.
Hugh A. McAllister, M.D.
William A. Hoggard, Jr., M.D.
Guy H. Branaman, Jr., M.D.
Jesse Caldwell, Jr., M.D.
Charles T. Pace, M.D.
Milton S. Clark, M.D.
W. Otis Duck, M.D.
Avon H. Elliot, M.D.
Paul R. Kearns, M.D.
Frank R. Lock, M.D.
Roy T. Parker, M.D.
Robert A. Ross, M.D.

MEDICAL - LEGAL COMMITTEE

The Medical-Legal Committee has met twice this year. The first meeting was held in Chapel Hill on November 14th, Following this meeting the Medical Committee was invited to attend a meeting sponsored by the North Carolina Bar Association at which an Institute on THE MEDICAL ASPECTS OF PERSONAL INJURY LITIGATION was held. Following this program a banquet by the Bar Association was held to which the doctors were invited. The second meeting was held at the Sir Walter Hotel in Raleigh on February 28th. Separate meetings of the Legal and Medical Committees were held in the afternoon, followed by a joint dinner meeting, at which ways were discussed to facilitate the Medical-Legal progress.

The demand for copies of the INTERPROFESSIONAL CODE has been so great that reprints were necessary. At a meeting in Raleigh on February 28, changes in our INTERPROFESSIONAL CODE were advised which are to encompass the provisions of the "NATIONAL INTERPROFESSIONAL CODE." These changes were agreed upon in respect to the state code previously adopted by the House of Delegates and these changes will be referred to the proper authority of the two associations for adoption as revised."

Several joint meetings at county level have been held throughout the state during the year, and letters are on file requesting assistance for future meetings. This Committee recommends continuation of the Medical-Legal Committee for further study.

s Bennette B. Pool, M. D., Chairman Millard B. Bethel, M. D. Connell G. Garrenton, M. D. June U. Gunter, M. D. Theodore S. Raiford, M. D. James Tidler, M. D.

COMMITTEE ON MENTAL HEALTH

Two Committee meetings were held during the year, one in Raleigh on November 2, 1958, and the second in Charlotte on March 8. 1959. Major consideration was given to: 1. Legislative request for a revision of N. C. General Statute 14-177 Bill regarding Crime against Nature 2. Cooperation with the N. C. Psychological Association through a sub-committee contact 3. Recommendations as to the increasing use of Hypnosis in the practice of medicine and dentistry in North Carolina 4. Close contact with the Mental Hygiene Clinics and other state institutions with responsibility in the treatment of mental illness, and 5. Rehabilitation of one referred physician.

Crime Against Nature and Sex Deviates: Dr. James Proctor, Dr. Wilmer Betts and Dr. Walter Sikes composed a sub-committee to study the present laws against Sex Deviates across the nation. It was reported that New York State had one of the best Statutes and this sub-committee prepared to proposed Statute changes in the present North Carolina Law to bring it more up-to-date with surrounding states and of New York State.

The Committee Health Committee approved the proposed Bill as submitted and asked the Legislative Committee of the State Medical Society to include this in their legislative agenda.

The major change in the new proposal of this Statute is to change the crime from a felony to a misdemeanor under certain circumstances. It also provides for psychiatric consultation and treatment for sex deviates.

The Medical Society, through its Legislative Committee and the Executive Council, did not feel this Bill should be sponsored by the Medical Society but referred it to either one of the law enforcement agencies or the Psychiatric Society for sponsorship, Several groups have expressed interest in the proposed changes but as yet, no active sponsorship has been promised.

Cooperation with the Psychological Association: A sub-committee headed by Dr. Joseph B. Stevens was appointed to keep in touch with the psychological association and their plans to reintroduce any legislative bill requesting Certification in the 1959 General Assembly. To date, no report has been received as to any action proposed by this

group this year.

Recommendations as to the Use of Hypnosis in Medical Practice: The Committee approved the action and recommendations of the A.M.A. summary statement in the September 13, 1958, A.M.A. Journal: quote: "General practitioners, medical specialists, and dentists might find hypnosis valuable as a therapeutic adjunct within the specific field of their professional competence. should be stressed that all those who use hypnosis need to be aware of the complex nature of the phenomena involved. Teaching related to hypnosis should be under responsible medical or dental direction, and integrated teaching programs should include not only the techniques of induction but also the indications and limitations for its use within the specific area involved. Instruction limited to induction techniques alone should be dscouraged.

Certain aspects of hypnosis still remain unknown and controversial, as is true in many other areas of medicine and the psychological sciences. Therefore, active participation in highlevel research by members of the medical and dental professions, is to be encouraged. The use of hypnosis for entertainment purposes is vigorously condemned."

Rehabilitation: One member of the Wilson County Medical Society, having lost his medical practice license almost two years ago, appeared before this Committee in November requesting guidance and a hearing. Inqquiry has been made by the Chairman to the Board of Medical Examiners and there is a possibility that after two years suspension of license, a renewed effort might prove successful. At the present time, this physician is employed at the University of North Carolina School of Medicine in the Pathology Department, Reports claim that he is adjusting very well to this type of work.

Mental Health Clinics: Dr. John A. Fowler reported in March that North Carolina now had ten clinics, the new one being in Wilson, N. C. The Committee reaffirmed their interest and support of these clinics and commended the work being carried out by these facilities. Dr. Lloyd Thompson reported that Salisbury has a clinic with one lady psychiatrist, Dr. Higbee. Gastonia is still working towards getting a clinic in their area of the state.

The Committee denounced any false publicity recently appearing connecting the Mental Health Association with Communism. It was reported that some literature was being distributed anonymously making such claims and that it had already caused some reper-

cussion in Burlington, N. C.

Legislation: The Committee on Mental Health continues to be interested in all programs, facilities, and services for the mentally or emotionally disturbed persons and maintains close contact with the N. C. Board of Hospital Control, the State Board of Health, Private treatment centers, and the relationships of the psysicians to these services. Several appropriation requests are being introduced into the 1959 General Assembly, but at this time, no definite action can be reported.

Recommendations: 1. The Committee recommends increased opportunities for psychiatric training for general practitioners in seminar and post-graduate courses throughout the state. 2. Continued support to the establishment of Mental Health Clinics.

/s/ Allyn B. Choate, M.D., Chairman Wilmer C. Betts, Jr., M.D. E. W. Busse, M.D. John W. Ervin, M.D. John A. Fowler, M.D. Thomas T. Jones, M.D. Hans Lowenbach, M.D. James T. Proctor, M.D. Walter A. Sikes, M.D. Joseph B. Stevens, M.D. R. Burke Suitt, M.D. Lloyd J. Thompson, M.D. David A. Young, M.D.

COMMITTEE ON NECROLOGY

The Committee on Necrology has not had a formal meeting. However, it has stimulated activity in reckoning the Necrology listings of all physicians who have died during the period of April 1, 1958 and April 1, 1959, and documentations from various sources have been secured and filed at Society Headquarters in the form of verified press reports of deaths occurring within the State and by vital statistic records.

The Committee has caused the names to be properly registered for the year as follows: (1) Deaths for 1957-1958 have been published in the Roster with solemn designation; (2) Likewise. listing of 1958-1959 deaths have been listed in the Official An-

nual Sessions Program.

Finally, in cooperation with the Committee on Arrangements and the Society Headquarters, a Memorial Service of a suitable nature has been prepared to be conducted on Sunday, May 3. 1959, at Asheville during the course of the Annual Sessions.

s Charles H. Pugh, M. D. Chairman

COMMITTEE ON NOMINATIONS

(This Committee met in Raleigh March 21, 1959, formulated a report and submitted same as required as a sealed report to the President of the Society. It may have addenda report at the Annual Sessions.)

Graham B. Barefoot, M. D. Chairman

THE PHYSICIANS COMMITTEE ON NURSING

This Committee has set regular quarterly meetings. For the past year these have been well attended and much interest is evidenced. It is the desire of the committee to keep the profession informed regarding nursing.

On the National Scene, there is consideration of combining the American Nurse Association and the National League for Nursing into one body. Many favor this. Others

do not.

The American Hospital Association last fall appealed to the National League for Nursing to convert its board of accreditation of nursing schools into a joint board with representatives from the American Medical Association, American Hospital Association, American Nurse Association, and National League for Nursing. Up to the present, the National League for Nursing considers accreditation the function of nurses only.

Recently there has been an increase in the

country in the percentage of failures on state board examinations for licensure. An explanation has been offered by the American Nurse Association which is not entirely satisfactory. We, in North Carolina, have sent a resolution to the Trustees of the American Medical Association to ask for medical representation on the Blueprint Committee which selects the questions for the state board examinations. We hope that this will be acted upon favorably.

Legislation at the national level is being proposed for federal grants and scholarships for collegiate education in the field of nursing. The American Medical Association News in February or March states "HR-1251 by Green (D-Ore) to Interstate and Foreign Commerce Committee proposed \$20 million

program." We are opposed to this.

For North Carolina, representatives from this committee have served on the North Carolina Committee on Nursing and Nursing Education and the North Carolina Commission on Patient Care. These committees meet at Chapel Hill at different hours on the same day that our committee meets quarterly. In conjunction with the Commission on Patient Care an effort is being made to establish local committees in each hospital in North Carolina to improve patient care. In the hospitals there is usually representation by the administration, nursing and medical staffs and sometimes the board of directors. Nursing plays such a large part in patient care that our committee is especially interested in this project. Our committee makes an effort to publicize activities in the nursing field. An article by Dr. Moir S. Martin presented at the Asheville meeting 1958 was printed in the State Medical Journal, May 7th, 1958. Another article on Improving Patient Care was presented in Hospital News, Durham, September-October, 1958. Legislation is being prepared for the present general assembly asking for scholarships for nursing students on the basis of financial need for students who are physically, intellectually and morally qualified. Also in the same bill we are asking for direct financial aid by the state for nursing schools. Both of these requests have been approved by the Executive Council of the State Medical Society. There is a special need for the latter particularly for the three year diploma schools in our voluntary hospitals. The Committee trusts that every opportunity on the part of medical men will be used to promote this legislation.

> /s/ Dr. H. L. Brockmann, Chairman Dr. Robert R. Cadmus Dr. Badie T. Clark

Dr. James E. David Dr. Moir S. Martin Dr. David T. Smith Dr. Vernon H. Youngblood

COMMITTEE ON OCCUPATIONAL HEALTH

The third annual Governor's conference on Occupational Health was held at Chapel Hill,

February 5, 1959.

The sixth annual Occupational Health Seminar was held at Chapel Hill February 6, 1959. Programs for both the above meetings were excellent. They were interesting, instructive and were well presented.

We are indebted to Wm. P. Richardson, M. D., who did practically all of the work in setting up both programs. He is to be congratulated for his faithful devotion and

untiring efforts.

Your committee met at the conclusion of the Governor's conference. Three members were absent, B. Dixon Holland, M. D., Secretary AMA Council on Industrial Health, John M. Kester, M. D. and Wm. B. Townsend, M. D. representing the Mecklenburg County Medical Society's Committee on Industrial Health, were present by invitation. Basic plans for the twentieth annual AMA Congress on Industrial Health were outlined. This meeting will be held in Charlotte in 1960. Representatives from the Charlotte Council on Occupational Health of which Dr. Townsend is Chairman, were also present for consultation.

The Governor's Council and Charlotte Council will both assist in sponsoring the

Congress.

North Carolina was signally honored when the AMA Council accepted our invitation to hold the Congress in North Carolina in 1960. It is our sincere hope that the officers and committeemen especially as well as the members of the Society in general will do everything possible to make the first AMA Congress on Industrial Health held in North Carolina a glowing success.

The program is not complete but will be tailored to benefit small industry and the General Practitioner in his role as a small

plant physician.

/s/ Harry L. Johnson, M. D., Chairman B. F. Cozart, M. D. Victor M. Crescenzo, M. D. MacRoy Gasque, M. D. John M. Hall, M. D. John E. McLain, M. D. C. Hunter Moricle, M. D. Wm. P. Richardson, M. D. Logan T. Robertson, M. D.

COMMITTEE ON POSTGRADUATE MEDICAL STUDY

The Committee on Postgraduate Medical Study met on December 7, 1958 at the Sir Walter Hotel. Those present were: Joseph B. Stevens, M. D.; David Cayer, M. D.; Amos N. Johnson, M. D.; Samuel L. Parker, M. D.; William P. Richardson, M. D.; Frank R. Reynolds, M. D.; James T. Barnes; and William N. Hilliard.

Dr. Stevens called attention to a letter from Mr. James T. Barnes dated December 3, 1958, making reference to the interest of the State Board of Health in regard to a seminar on the subject of Staphylococcal Infection. The staff member, from the Department of Epidemiology of the State Board of Health, apparently indicated that the board proposed to stage some time early in next year (1959) a seminar on the subject of Staphylococci Infection which seems to be a

general problem.

Following considerable discussion of the problem, the Committee suggested that an attempt be made to accumulate the names of the Chief of Staff for every hospital in the state. This list was to be solicited from the President of the respective County Medical Society and the list to be kept in the Headquarters Office of the State Medical Society for use under the direction of the Committee on Postgraduate Education. In addition to asking for the name of the Chief of Staff of the hospital, such an inquiry should also ask if there is a special committee or person at that hospital particularly

interested in the Staph problem.

Dr. Richardson commented that the UNC Postgraduate Extension Courses were still fairly popular and that the demand was holding up at a level just above the self

supporting level,

Dr. Stevens reviewed correspondence from the National Foundation announcing 16-million dollars in scholarships to be awarded throughout the nation and allocated to the states on basis of population. North Carolina will get fifteen of the scholarships annually, three each in the following health professional categories: Medicine, Medical Social Work, Nursing, Physical Therapy, and Occupational Therapy.

Each of the National Foundation scholarships will be for \$500 a year for four years or a total of \$2,000 providing the recipient maintains the prescribed scholastic stand-

ards.

The applications for the National Foundation scholarships will go first to the County Chapters of the National Foundation for forwarding to a screening group, probably by a committee named by the State Medical Society. However, no members of medical schools of the state would be allowed on the screening group. The scholarships are to be publicized through the local chapters of the National Foundation.

The Committee felt that the Public Relations Bulletin of the State Society should continue the practice of enclosing a listing of Postgraduate opportunities in North Carolina periodically whenever information about these opportunities could be obtained. This was thought to be a worthy enclosure with the Bulletin even though the publication of the "What to Do Bulletin" covered much of the same material, the Committee feeling seemed to be that Postgraduate Opportunities was an important enough subject to list in as many places as possible. It was also suggested that a reference in the Bulletin should be made to the special issue of the Journal of the American Medical Association which lists twice a year Postgraduate opportunities for the nation.

Dr. Amos Johnson brought up the subject of television clinics for members of the Society to be broadcast early in the day from some of our Medical Schools. It was felt that excellent coverage of the state would be possible by using certain key stations. After some discussion the matter was referred to Dr. Richardson and Dr. Stevens for further investigation.

/s/ Joseph B. Stevens, M. D.,
Chairman
David Cayer, M. D.
W. Otis Duck, M. D.
Amos N. Johnson, M. D.
Wm. McN. Nicholson, M. D.
Samuel L. Parker, M. D.
William P. Richardson, M. D.
Frank R. Reynolds, M. D.

COMMITTEE ON POLIOMYELITIS

This will constitute a detailed report of activities of the Medical Society's Poliomyelitis vaccine Committee for 1958-1959, together with summaries of five surveys conducted in an effort to get a complete picture of the immunization status in this State. This report was withheld deliberately until the General Assembly passed the Compulsory Poliomyelitis Immunization Bill.

Enactment of our bill could not have been achieved without the cooperation of my committee members, the State Board of Health, the Executive Committee of the Medical Society, and the medical profession all over the State.

The media of mass communication—radio, T-V, and especially the press (both news and editorial) — rendered an incalculable public service by their continued and outspoken support of our efforts.

At the critical public hearing before the Joint Committee of the Senate and House Drs. Dave Rose, Roy Norton, Hubert Poteat and Charles Bugg rendered effective and outstanding service in support of the bill.

Senator (Doctor) Dave Rose of Wayne County shepherded the bill through the Legislature with a consummate display of statesmanship. The Medical Society owes this retired physician a tremendous debt of gratitude for his untiring efforts and potent legislative skills exerted so expertly and so often in behalf of organized medicine.

Dr. Rachel Davis of the House, and Mr. John Anderson, our Attorney, also rendered yoeman service in carrying the bill through

to its passage.

It is my considered opinion that the Poliomyelitis Vaccine Committee as a specialized committee has now largely fulfilled its function and may well be disbanded. However, there is, I believe, urgent need for a "Committee on Immunization in General" to be appointed to function constantly. The general level of all immunization in our citizens is tragically low, as regards diphtheria, tetanus and smallpox — as well as poliomyelitis. Adults in particular constitute the "neglected age" of man in our State in this respect. The percentage of those over 20 (except for the group recently in the Armed Forces) who have been immunized against diphtheria, tetanus, smallpox and poliomyelitis, is unbelievably low. The number of adults who are exposed each year in North Carolina to the twin hazards of tetanus or of serum reactions from antitoxin, because of lack of basic immunization, is incredible.

During 1956, 6,200 persons were given tetanus antitoxin in 13 North Carolina hospital emergency rooms. The number treated similarly in other hospitals and in physicians office, and the overall incidence of serious serum reactions, may only be conjectured.

The suggestion is made that such a committee might well include a pediatrician, an internist, a general practitioner, a health officer, a surgeon and an obstetrician. A program implementing a broad four-pronged attack on the four diseases might then be outlined to the county societies with sufficient flexibility to make it adaptable to local needs.

It is my earnest hope that these suggestions will not be regarded as presumptuous by the present or incoming executive officers of our State Society.
/s/ S. F. Ravenel, M. D.,
Chairman

April 3, 1959 Greensboro, North Carolina

REPORT OF ACTIVITIES 1958-59

POLIOMYELITIS VACCINE COMMITTEE

S. F. Ravenel, M. D., Chairman
June 1958 Formation of Committee: new appointments to membership, deletions, and reappointments.

October 19 Meeting in Greensboro to (1) lay plans for Legislative Cam-

paign to present Compulsory Poliomyelitis Immunization bill to the General Assembly, (2) Formation of bill.

November 9 Chairman Ravenel met with Legislative Committee of Society in Raleigh.

November 28 Letter from Chairman to Executive Committee and Poliomyelitis Vaccine Committee of each county society:

of each county society:
(1) Review of poliomyelitis situation

(2) Salk vaccine levels; North Carolina and U. S. A.

(3) Mechanics of presenting bill

(4) Procedures in assistance by County Societies in lining up Assemblymen of each district for support of the bill.

November 14 Letter from Chairman to
every college, junior college,
preparatory school and summer camp in North Carolina
with regard to urging Poliomyelitis immunization as a
pre-requisite to admission.

December 11 North Carolina divided into

North Carolina divided into zones. Each member of Society Poliomyelitis Vaccine Committee given specific counties, in which they were to see that those societies informed and influenced their Assemblymen in favor of the bill.

December January February 1959 "Trouble-shooting"; checking on Poliomyelitis Vaccine Committee members to see if they were making contact with their county societies and the Assemblymen for each; securing endorsements from rebruary 5 ential groups and agencies who could help push the bill.

Dr. Foard's meeting in Greensboro with Region III Director of U. S. Public Health Service, Dr. Gillis to

various interested and influ-

review state and nation-wide poliomyelitis picture.

February 9 Letters to Army, Navy, Air Force, National Guard of this district to find out status of immunization against poliomyelitis of Reserves, and to inquire as to feasibility of making poliomyelitis immunization mandatory for all Armed Forces personnel un-

February 10 Same thing re inmates of Prison System.

der 40.

February 24 Letters to all orphanages, child-caring institutions, and non-public secondary schools with regard to poliomyelitis immunization status of inmates or students.

February 18 Hearing before Joint Health Committees of Senate and House of North Carolina General Assembly.

March 7

Guest Speaker at meeting of North Carolina Chapter of American Women in Radio and Television, to express appreciation of outstanding public service by their media in coverage of the poliomyelitis immunization program for the

March 13 State.
Compulsory Poliomyelitis Immunization Bill passed by Senate unanimously.

March 27 Compulsory Poliomyelitis Immunization Bill passed by House 72-3.

/s/ S. F. Ravenel, M. D., Chairman

SUMMARIES OF SURVEYS MADE BY POLIOMYELITIS VACCINE COMMITTEE 1958-'59

I—COLLEGES, JUNIOR COLLEGES, PREPARATORY SCHOOLS, BOTH PUBLIC AND NON-PUBLIC:

58 inquiries sent November 14, 1958

As of April 1, 1959 27 no responses

31 responses — or 53.5%

19 do now require - or will
require - immunization

from 1959-60 on

8 will consult their Boards and decide later

4 gave nebulous answers

II - CAMPS:

58 inquiries sent November 14, 1958

As of April 1, 1959 38 no responses

20 responses - or 34.5%

7 do now require immunization

11 will require immunization from 1959-60 on

2 nebulous responses

III— NON-PUBLIC SECONDARY SCHOOLS:

39 inquiries sent February 24, 1959

18 no response

21 responses - or 53.8%

2 definitely will require immunization 1959-60 on

2 probably will

17 do not require immunization, and made no commitment to do so

IV-PRIVATE ORPHANAGES:

31 inquiries sent February 24, 1959

8 no responses

23 responses - or 74%

20 do now require immunization

1 does when can - emotionally disturbed children

1 probably will require immunization, 1 does not require immunization, and made no commitment to do so.

V—STATE INSTITUTIONS FOR MEN-TALLY DEFECTIVE, EMOTION-ALLY DISTURBED, EPILEPTICS:

5 inquiries sent February 24, 1959

2 no responses

I does require immunization

I does not require immunization, but majority of patients under 40 have been immunized

1 does not require immunization, and no commitment made to do so.

VI— STATE CORRECTIONAL SCHOOLS:

5 inquiries sent February 24, 1959

3 no responses

1 now in process of immunizing all students

1 does not require immuniza-

tion, and no commitment to do so.

VII—STATE SCHOOLS FOR BLIND AND DEAF:

2 inquiries sent February 24, 1959

Neither school requires immunization as yet, but will probably institute program now that Compulsory Immunization Bill has been passed by the Legislature.

VIII— STATE PRISON SYSTEM:

Letter to Director W. F. Bailey on February 10, 1959, inquiring as to feasibility of immunizing all prisoners under 40. Response from Mr. Bailey indicated that he would investigate to see what could be done under budget limitations to institute such a program, Dr. J. W. Roy Norton assured Chairman Ravenel by telephone that he would see to it personally that such a program is instituted.

IX— ARMED FORCES PERSONNEL:

Letter from Dean W. C. Davison of Duke University School of Medicine quoting "upon the advice of the Armed Forces Epidemological Board and the Concurrences of the Surgeon General of the Army, Navy, and Air Force, the administration of poliomyelitis vaccine was made mandatory for all military personnel under forty years of age."

Chairman Ravenel inquired of the Commandant of the Sixth Naval District, the Commanding Officer of the Third Army, the Commanding Officer of the 14th Air Force District if this directive also included North Carolina Reserve Units of the Armed Forces, The same inquiry was made of the Commanding Officer of the North Carolina National Guard regarding the personnel of that organization.

Inasmuch as these commanding officers were not able to give a definite answer to this inquiry, a letter was addressed to Surgeon General LeRoy Burney of the Public Health Service. This inquiry was in turn forwarded to the Department of Health, Education and Welfare's Assistant Surgeon General David

Price, Chief, Bureau of State Services. He referred it to Assistant Secretary of Defense for Health, Dr. Frank B. Perry, who stated that Reserve Units operate under their own regulations, and so are not included in this directive, until such time as they may be called to active duty. Time has not allowed further committee action on this.

/s/ S. F. Ravenel, M. D., Chairman

November 7, 1958

The Poliomyelitis Vaccine Committee of the Medical Society of the State of North Carolina, in an effort to eradicate paralytic poliomyelitis in this State, has embarked on a campaign to induce every summer camp to make adequate immunization against poliomyelitis a prerequisite to admission. (I believe that most camps now require immunization against smallpox, tetanus, diphtheria.)

At present only about 40% of our entire 0-20 age group, and 30% of our teen-agers,

have had three doses.

In the event that poliomyelitis breaks out in epidemic form in North Carolina (and it conceivably may since our immunization level is little better than that of Detroit) the individual camp director might be comforted to realize that the vast majority of his campers were adequately protected against paralysis.

It is our earnest hope that you will see fit to institute this requirtment at your camp. I shall consider it a great favor if you will

inform me as to your decision.

Sincerely yours,
Samuel F. Ravenel, M.D.,
Chairman,
Poliomyelitis Vaccine Committee
of the Medical Society of the
State of North Carolina

November 14, 1958

The Poliomyelitis Vaccine Committee of the Medical Society of the State of North Carolina has decided to undertake a campaign to immunize our teenage and young adult population against poliomyelitis. At present only about 40% of the entire 0-20 age group, and 30% of the teenagers have had three doses.

As a part of this effort we are writing every college, junior college and preparatory school in the State requesting that they make adequate poliomyelitis immunization (currently, at least three doses) a prerequisite for admission. (The vast majority of these institutions already require diphtheria,

tetanus and smallpox immunization.)

Duke University, the University of North Carolina, the Woman's College of the University, North Carolina State College and Wake Forest College have already made this a requirement for admission.

We trust that your institution will see fit

to do likewise.

In case of Student Health Director is concerned lest some penicillin sensitive youth be made ill by a penicillin reaction from required Salk vaccine, the Wyeth Salk vaccine contains no penicillin and may be given to such persons with absolute impunity.

The over-all safety of Salk vaccine is revealed by the fact that no case of poliomyelitis has been traced to the vaccine since May 1955. During this time over 200 million doses have been administered in this coun-

trv.

I shall consider it a great favor if you will inform me as to your decision.

Sincerely yours,
Samuel F. Ravenel, M. D.,
Chairman,
Poliomyelitis Vaccine Committee
of the Medical Society of the
State of North Carolina

February 24, 1959

The Poliomyelitis Vaccine Committee of the Medical Society of the State of North Carolina is striving to have our population under 40 years of age immunized against paralytic poliomyelitis. Accordingly, we are inquiring into the immunization status of inmates of all North Carolina institutions such as yours.

I should like to know:

(1) Your inmate, or student, population and age group;

(2) Is poliomyelitis immunization mandatory

in your institution?

(3) If it is not, will you consult your medical advisors and/or executive board in regard to the possibility of making it compulsory?

The urgent necessity for protecting the resident population of such institutions against paralytic poliomyelitis is clearly evident.

I trust that you will not consider my request presumptuous or an unwarranted interference in the affairs of your institution. We are deeply concerned over the tragically low level of protection against paralytic poliomyelitis in our young people.

I shall be grateful for an early reply, so that I may report to the Medical Society.

Respectfully yours, S. F. Ravenel, M. D., Chairman Poliomyelitis Vaccine Committee of the Medical Society of the State of North Carolina

COMMITTEE ON PUBLIC RELATIONS

The Committee has held two full-scale meetings during the year. In these meetings general planning and policy-making was carried out. In the execution of these policies and plans and in the many day-to-day problems that beset those interested in the public relations of medicine, frequent communication by telephone and by correspondence has been maintained between committee members and with other Society officials. The Committee Chairman and the Executive Assistant for Public Relations have been in virtual daily communication as various matters arose demanding decisions which could not await a Committee meeting.

An innovation in the activities of this Committee this year was the Conference of County Medical Society Officers which was held in Pinehurst on January 10, 1959. The purpose of this Conference was to assist in the orientation of newly elected county society officials, to acquaint them with their duties and responsibilities, to delineate certain problems facing medicine at the moment. and to suggest various avenues of assistance. Considerable favorable comment regarding the Conference was received from the participants. It is the feeling of the Committee that a similar program should be conducted in 1960 and that with certain refinements already planned we should have an even more successful Conference.

During the fall and early winter, the Committee sponsored a series of sixteen weekly 30-minute television programs after having been invited to do so by the University of North Carolina Television Station (WUNC-TV, Channel 4.) The series of programs covered a wide variety of health topics, some of the programs being produced live while others utilized appropriate films. Several physicians participated in these programs presenting the medical and scientific aspects of the program topic.

A Medical Society Exhibit was again sponsored during the North Carolina State Fair. October 14-19, utilizing an exhibit on Poisons prepared by Dr. Jay Arena and another exhibit on Childhood Accidents prepared by Dr. Barnes Woodhall. The exhibit also offered a blood typing service whereby approximately 1,000 persons availed themselves of the opportunity to determine their blood group and RH factor and to receive a pocket-size identification card indicating this infor-

mation. Educational literature distributed at the Fair Booth included first aid charts, personal health information cards, family health record booklets. and a pamphlet entitled. "What Everyone Should Know About Doctors."

One-year complimentary subscriptions to the AMA Magazine entitled "TODAY'S HEALTH" have been sent to the Governor, Council of State, Supreme and Superior Court Judges, members of the North Carolina General Assembly, and to United States Senators and Representatives from this state.

The Committee has continued to support the activities of the North Carolina Academy of Science and its promotion work in the recruitment of scientists and the promotion of High School Science Fairs. It is the hope of the Committee that this project might eventually contribute to the availability of larger numbers of better qualified high school science teachers, thus improving the science training for prospective premedical students. The Committee again plans to invite one High School Science Fair winner to display their exhibit at the Annual Meeting of the State Medical Society.

The Committee sponsored a "Senior Day" at the University of North Carolina School of Medicine on May 22, 1958, at which time a program on the socio-economic aspects of medicine was presented followed by a dinner for the senior medical students. The dinner was co-sponsored by the Hospital Saving Association.

The Committee has continued its distribution of our most popular item of literature: The first-aid posters appropriate for placing on the inside of home medicine chest doors. In addition to the distribution at the State Fair, these have been distributed through schools, Four H. Clubs, and many other civic and community organizations.

The Public Relations Bulletin is being published during 1959 on a monthly schedule except for the months of May, July, and August for a total of nine issues during the year. The Committee feels that the Bulletin offers a good means of communicating upto-date, "last-minute" information in a brief, succinct fashion to the Society membership, and our information indicates that this publication is probably the most widely-read of any Society publication.

Dr. Edgar T. Beddingfield and Mr. William N. Hilliard, on behalf of the Committee, attended the Public Relations Institute conducted by the American Medical Association on August 27-28 of last year in Chicago. The meeting supplied helpful information and useful techniques for implementation in the

public relations program of the State So-

ciety.

More than 20 series of transcribed radio programs on health topics were scheduled over various radio stations throughout the state, each series involving some thirteen individual fifteen minute programs for a total of more than 260 programs. Weekly "HEALTH MAGAZINE OF THE AIR" transcribed radio programs have also been furnished to 30 radio stations. These were produced by the American Medical Association.

The Committee has endeavored to cooperate with other committees of the State Society wherever possible. A considerable number of showings of the films in the medicallegal series was arranged for county medical society meetings in cooperation with the So-

ciety's Medical-Legal Committee.

One of our projected activities which failed to materialize because of difficulties in arranging the mechanics as to time, place, participants, etc., was a medical-press meeting. We feel that the tremendous amount of work done in this sphere by our predecessors should not be dropped now and we strongly recommend that such a meeting be held in the next year.

Finally, the Committee wishes to officially express our heartfelt gratitude to the staff at the Society Headquarters Office and in particular to Mr. Barnes and Mr. Hilliard for all their help in the operations of our program. They have performed yeoman service and we could not have functioned without

them.

/s/ Edgar T. Beddingfield, M. D. Chairman

COMMITTEE ON PHYSICAL REHABILITATION

During the year 1958-1959 no concrete problems have been referred to this Committee for consideration and action.

As Chairman of this Committee, I wish to report that I am also a member of the Medical Advisory Committee of the Department of Vocational Rehabilitation of North Carolina and in that capacity have regularly met with other physician members of this Committee and advised with the Department of Vocational Rehabilitation in regard to medical matters upon which the Department sought advice. There is an excellent status of liaison with the Department of Vocational Rehabilitation through the efforts of this Committee widely representative of the medical specialty in North Carolina.

/s/ George W. Holmes, M. D.,

Chairman

Charles H. Ashford, M. D. F. P. Dale, M. D. J. Leonard Goldner, M. D. Arthur H. James, Jr., M. D. George H. Wadsworth, M. D.

REPORT COMMITTEE ON RURAL HEALTH AND EDUCATION

As Chairman of the State Medical Society's Committee on Rural Health and Education. I submit the following Summary Report of the activities of this Committee and the Health Education Consultant for the vear 1958-59.

I. ACCOMPLISHMENT OF 1958-59

OBJECTIVES:

A. Sponsor State Community Health Workshop in lieu of annual state conference. Action: held in Raleigh on November 21 and 22, 1958

B. Sponsorship of five district conferen-

Action: Conferences held in Districts 4, 6, and 8 with districts 2 and 10 pending

C. Cooperation with and sponsorship of the 4-H Health Improvement Program

1. One year subscriptions to Today's Health Magazine to county Kings and Queens of Health A total of 140 subscriptions given

by State Medical Society.

Cost: \$210.00

2. Gift Certificates presented to county health winners by Medical Auxiliary representative at local recognition program. Objective accomplished in most of the counties during the fall of 1958 with some few to be presented in 1959.

3. One trip to National 4-H Club Congress in Chicago, November, 1958. The recipient was the State Health King-Jimmie Jones from Union

County.

Cost: \$165.00

4. Certificates presented to the State King and Queen at State College on November 27, 1958 by Health Education Consultant on behalf of the Rural Health Committee State Chairman.

D. New and continued rural or community health programs or activities at local level by Districts:

From the returned questionnaires of County and District Rural Health

Chairmen.

1. Many of the chairmen had participated with the public health clinics, voluntary agency programs, and community health activities.

- 2. The most frequent programs included: immunizations, maternal and infant care, cancer education. diabetes projects, tetanus immun_ ization campaigns, and safety education
- 3. The major community groups requesting assistance from the county medical society were: Medical Auxiliary, civic clubs, home demonstration clubs, farm organizations, schools, Boy Scouts, and the county health and welfare departments
- 4. Eight counties reported having some committee nucleus for planning community health activities and programs.
- 5. Three counties reported joint cooperation between the county welfare departments and the county medical society for evaluation of appliances and especially those applying for disability assistance.

District I. Currituck County:

- 1. Sponsored health and safety section at County Fair
- 2.4-H Certificates presented by county chairmen

Camden County:

- 1. Participated in a district Negro Teachers Workshop at the Marion Anderson High School of Camden County
- 2. Talks given at high schools in both Currituck and Camden Counties
- District II. Washington County: comprehensive sanitation survey in cooperation with county health departments and home demonstration Clubs. Medical Society assisted in planning and organization.

Tyrrell County: Participation in a series of Farm Equipment Safety Demonstrations

Hyde County: Negro Teachers Meeting and High School Students. Attendance and participation by County Medical Society

Pitt County: Organization and planning for the 2nd District Community Health Workshop (canceled because of snow). Interest in establishment of Nursing School at Pitt County

Hospital and scholarships obtained for students once the school is established.

Craven County: Initiated and participated in three conferences, and two T. V. programs, sponsored by community groups with medical society cooperation.

Martin County: Participated and sponsored in immunization

program

Lenoir County: Active participation in home demonstration and 4-H club health activities, also civic club programs

Beaufort County: Active participation in Child Evaluation Clinic for the mentally reimmunization protarded. grams, special programs on obstetrical care and infant mortality

District III. Sampson County: Guidance given to planning a series of study club programs on mental health. Talks given to Medical Auxiliary unit and home demonstration clubs in the county

Directed Public Health Well-Baby Clinics.

- District IV. Wilson County: Assistance given to the establishment of the Wilson County Mental Health Clinic. Opened March,
- District V. Harnett County: Joint committee set up between medical society and Welfare Department for the review of disability claims for local screening. A rotating three-member medical committee meets regularly with local welfare agent and Welfare Board to review applicants.

Robeson County: Renewed interest in the formation of a county health planning committee initiated by county chairman

District VI. Franklin County: organizational conference in the interest of forming a county health service coordinating committee

Wake County: health educator served as advisor to Farm Bureau health programming for county units

Planning towards the formation of a county health committee for health service and educational programs

Orange County: medical society cooperated with the sec-ond Buckhorn Grange Health and Safety Fair by providing an exhibit and distributive materials

District VII. Cabarrus County: sponsored second annual county conference. Conducted countytetanus immunization program, some 50,400 injections

District VIII. Guilford County: cooperated in the second Health and Safety Fair in High Point

District X. Haywood County:

1. Organized Haywood County Better Life Council for teamwork approach to county health and welfare problems 2. Sponsored the third annual

Health and Safety Fair

3. Instigated and participated in countywide weight control clinic which involved major community health resources. A six week course

4. Initiated plans for Haywood County Manual of Health

Resources

5. Contributed Medical Society column "DOCTOR TELL ME" in county newspaper on doctor-patient relationships

Jackson County: Conducted "RURAL HEALTH DAY" in Sylva on July 26, 1958 spotlighting store window displays, demonstrations, exhibits, health movies, and parade.

E. Contact of State Committee with District and County Chairmen:

1. State Committee provided all county chairmen with Kits of materials and suggestions for promoting local health education programs.

2. Headquarters staff mailed all data formerly going to District Chairmen to County Chairmen for continued

follow-up contact.

3. Sent questionnaire giving county chairmen an opportunity to express opinions and to list activities for the year.

F. District Chairmen meeting with county chairmen at least once a year. Action: accomplished in Districts 2, 4, 6, and 8. District 10 meeting in April, 1959.

G. Procuring National Rural Health Conference for 1962: Action: Secured approval and invitation from State Medical Society Executive Council and renewed invitation to the Council at the Wichita National Conference, 1959

II. Evaluation of State Community Health

Workshop:

Four Primary objectives were set up by the Committee in sponsoring this work-

a. Communication among health and welfare personnel at state level to enhance mutual understanding and cooperation in interest of more successful health activity at the local level:

Objective accomplished:

b. Accumulation of composite data on certain major health problems to be used in district, county, and local community health education programs.

Objective partially attained:

c. Description of health activities and opportunities of statewide social systems in the interest of defining or redefining roles for more harmonious work relations in all communities. Objective partially attained, definite progress gained.

d. Recommendation for methods and means of future cooperative action of various health and welfare agencies and groups.

Objective partially attained.

Attendance: Attendance was by invitation alone and of some 200 invitations mailed, 161 persons attended the two-day workshop program. There were 33 counties represented. Sixty-five of the 161 had not attended a previous rural health conference. Twenty-seven agencies and organizations represented with the largest group in attendance being physicians

III. Evaluation of District Conferences: District 4 held their conference in Rocky

Mount on December 4, 1958. Attendance: 75 total. Ten counties represented with 61 of the 75 new contacts. Fifty-six of the 75 were volunteer community leaders. The three workshop topics discussed were: Nutrition, Chronic Illness and Mental Health.

District 6 held their conference at Butner State Hospital on January 21, 1959. Ten counties were represented with a total attendance of 112. Nineteen agencies and

organizations represented with 75 new contacts. The major emphasis was given to the problems of the chronically ill and the aging population. A panel discussion was held on detection, treatment, and rehabilitation of the mentally ill.

District 8: conference held at High Point on February 6, 1959 in conjunction with High Point Health and Safety Fair. Fifteen Counties with a total of 76 registered for the morning program. Twenty-two agencies and organizations represented with 47 new contacts. Problems of the Aged and the Guilford County Survey on Chronic Illness were two topics presented, with the third being an explanation of the Medical Society's interest in local evaluation and cooperative planning for the health care of these two segments of our population—chronically ill and the aged.

District 2: conference plans canceled on scheduled date. December 11th, due to weather conditions. Awaiting further rescheduling of conference date. A workshop program had been planned with four topic areas: Cost of Medical Care, Mental Health, Chronically Ill, Nursing Education and Training.

District 10: Plans to be developed in April, 1959.

IV. Projections for 1959-60 program:

A. Continuing programs:

- 1. Continue to be a service committee for the State Medical Society, in that that the Committee on Rural Health and Education and the Health Education Consultant cooperate with and serve all Medical Society Committees in bringing specific programs and information to the attention of county and community groups through joint planning committees, conferences, and special projects
- 2. Maintain liaison contact with Advisory Committee Organizations to help strengthen their interest and participation in community health programs.

3. Continue emphasis on Team approach at county level by:

—each county medical society to have an active health committee chairman who will be willing to serve as leader of the health team.

—at least one meeting be held each year of the county chairmen and representatives of health agencies and other organizations actively engaged in some type of health education or service program

—at least one new county health education project be developed and promoted in each district

4. Encouraging 4-H Club Health pro-

gram by:

—continuing Today's Health magazine subscription to county Kings and Queens

—providing one trip to National Club Congress for a State Health

Winner

—continuation of Medical Auxiliary cooperation in presenting Certificates to county health winners at the local recognition programs

5. Encouraging Physician Placement service program, especially in rural

areas.

- Continue working through existing community organizations and club programs to strengthen and direct their health activities
- 7. Preparing for the National Conference on Rural Health in North Carolina for 1962

Projected New Programs for 1959-60:

- Sponsorship of four Area Community Health Conferences to be held in the Fall of 1959: (tentative plans for: Northwest, Southwest, Southeast, and Northeast areas)
- 2. Dinner Conference for Community Health Analysis with Adv'sory Committee and Rural Health Committee Chairmen participating. This to be held in lieu of a state-wide conference or workshop. (Suggested date: September 13, 1959 in Raleigh)
- 3. Planning for Health Achievement Certificate Awards for Community Development Clubs. One each for the six area organization programs. (Awards to be given in 1960, the organization to be done in 1959)
- 4. Preparation of Health Education articles for Farm Publications.
- 5. Educational pamphlets to be produced by State Committee (at least two) for public distribution at conferences, fairs, club programs, and special health activities.
- 6. Series of Medical Society displays to be purchased or prepared for use at community health programs. These to be made available upon request to counties.
- Re-new interest in the formation of a North Carolina State Farm Safety Council.

/s/ Hugh A. Matthews, M. D.,
Chairman
William H. Romm, M. D.
R. Vernon Jeter, M. D.
John W. Nance, M. D.
B. E. Stephenson, M. D.
William Donald Moore, M. D.
Oscar S. Goodwin, M. D.
William F. Eckbert, M. D.
Fred C. Hubbard, M. D.
J. H. Cutchin, Jr., M. D.
Philip E. Dewees, M. D.
Rachel D. Davis, M. D.,
Consultant

SUPPLEMENTARY REPORT TO THE COMMITTEE ON RURAL HEALTH AND EDUCATION

Activities of the Health Education Consultant:

The health education consultant as a staff member of headquarters office has diverse responsibilities in connection with the total medical society's program of work. Working under the direction and supervision of the Executive Director, assignments and functions are carried out according to requests of Committee chairmen and the Executive Director. Since major functions are in the area of Community Health programs, this report is so attached to the report of the Committee on Rural Health and Education.

In the area of Rural Health and Education, major activities relate to: 1. assisting the State Committee Chairmen in planning, organization, and follow-up on Committee approved activities 2. assisting district and county rural health chairmen in planning community health conferences and special community health projects, such as fairs, programs suggestions, and meeting with county health committees, etc., and 3. serve as liaison contact between the State Committee and member organizations of the Advisory Committee and other lay groups interested in improved community health services and practices.

In 1958-59 assistance was given the District Chairmen in planning the community health conferences held in Rocky Mount, Butner, and in High Point. The Greenville conference was planned and scheduled for December 11, 1958 but was canceled because of weather conditions. Assistance will be given to the 10th District in April for their conference at Brevard. These district conferences were held as follow-up to the State Community Health Workshop held in Raleigh on November 21 and 22, 1958.

On the local level, assistance was given medical society chairmen in Haywood County, Jackson County, Guilford County (High Point), Franklin County, and in Cabarrus County for special health activities. Cooperation was given by the State Society to the Buckhorn Grange Community Health and Safety Fair in Orange County.

Liaison contact with Advisory Committee

Organizations:

1. Direct assistance was given the State Medical Auxiliary for their annual workshop held in Winston-Salem in September; for local programs in Smithfield, Durham, and High Point. The Medical Auxiliary cooperated with the State Committee on Rural Health by presenting Gift Certificates to county 4-H Health Kings and Queens on behalf of the county and state medical societies. Close liaison contact has been established with the State Chairmen of the Medical Auxiliary's Committees on Community Health, Safety, and Mental Health.

2. Served as consultant and member of health committees of:

- a. N. C. State Grange b. Home Demonstration Federation c. N. C. Public Health Association d. Advisory Committee for Community Development Clubs e. Consultant to the N. C. Farm Bureau
- 3. Served as area judge in the Western Community Development Contest
- 4. Maintained as liaison contact for professional and lay organizations for all Advisory Committee member organizations and full-filled assignments upon request.

Liaison contact with other Associations and Organizations:

- 1. Continued to serve as Editor of the N. C. Health Council Newsletter (quarterly publication). Also a member of the Executive Committee of the Health Council. Served this year on the Health Council Directory Committee.
- 2. Cooperated with the N. C. Dairy Industry Promotion Committee in sponsorship of "June Dairy Month" by serving as Assistant Women's Chairman for 1958 and Assistant State Publicity Chairman for 1959.
- 3. Special assignment by the Council on Rural Health of the American Medical Association:

A course on Health Education and Community Organization was offered to Agriculture Extension Agents in the Regional Extension Summer School at the University of Arkansas during the summer of 1958. The health education consultant had the privilege of teaching this three week's course at the request of the American Medical Association and with the cooperation of the N. C. Medical Society.

Assistance given other Medical Society Committees:

1. Attending and taking Minutes for: Physicians Committee on Nursing; Mental Health; Committee on Chronic Illness, plus the Committee on Rural Health

2. Fulfilling specific requests of Committee

and or Commission Chairmen

3. Attending all Executive Council Meetings; Officers Workshop; State Annual meeting; and other Committee meetings upon request of the Chairman or Executive Director

A total of 33 Medical Society Meetings attended from April, 1958 through March, 1959.

Cooperation given to the Physician Placement Service program of the State Society:

- 1. Assistance with office corespondence with communities and physicians
- A total of 15 field visits made to communities or with physicians seeking additional medical personnel.
- 3. Eleven office conferences with either physicians or community leaders.

/s/ Annette S. Boutwell Rural Health Consultant

COMMITTEE ON SCHOOL HEALTH

The Medical Society's Committee on School Health has continued its interest in the promotion of county society committees, as recommended by the 1957-58 annual report. To assist county chairmen in promoting better relationships with educational leaders, public health personnel, and with the parents of school children, a county chairman's guide sheet was prepared by the State Committee and distributed to county medical society presidents and secretaries to be passed on to appointed county school health chairmen.

Buncombe County is an excellent example of a well organized and active county school health council. Under the guidance and leadership of Dr. Irma Henderson Smathers, a member of the state committee, this group has demonstrated on the local level improved planning, coordination, and evaluation of school health problems and resources. This committee recommends increased attention to the coordinated effort on the part of all interested leaders and health service personnel to this important segment of our population, the school age child.

In January, 1959, the Committee on School Health was invited to attend a joint meeting in Raleigh, N. C., of the State Board of Health and representatives of the Dental Society and Medical Society to discuss utilization of the school health correction funds.

No other committee meeting was held during the year.

The Seventh National Conference on Physicians and Schools, sponsored by the American Medical Association, is scheduled to be held at Highland Park, Illinois, October 13-15, 1959.

Recommendations: The State Committee on School Health wishes to continue its interest in the promotion of county planning and organization of school health committees for improved health instruction and health services, with increased emphasis given family responsibility for early detection and correction of remedial defects of school age children.

 Appointment of County Medical Society School Health Committee Chairmen; formation of County School Health Committees for local planning and evaluation

 Recommends that representation from the Committee be present at the A.M.A. 7th National Conference on Physicians and Schools in October, 1959

3. Continued medical leadership and guidance in all phases of the school-health program in North Carolina.

orth Caronna.
/s/ Charles H. Gay, M. D., Chairman
Clarence Lee Corbett, M. D.
Jean Davidson Craven, M. D.
Irma C. Henderson Smathers,
M. D.

Floyd L. Knight, M. D. Wm. C. Hunter, M. D. Robert C. Pope, M. D. Wm. T. Rainey, M. D. Wayne S. Montgomery, M. D.

COMMITTEE ADVISORY TO STUDENT AMA CHAPTERS INTO NORTH CAROLINA

The Committee was called to order in the Tobacco Club of the Washington Duke Hotel, Durham, North Carolina, at 5:00 P.M., Sunday, October 12, 1958, by the chairman, Dr. Harris. All members of the committee, with the exception of Dr. John Nance, were present. The faculty advisor from each of the medical schools was present with the president or representative of his AMA Chapter. Dr. Hendrix of Duke University was present with Mr. H. A. Wilkerson representing the Duke Chapter. Dr. Richard Myers of Wake Forest was present with two representatives of the student chapter there, Mr. G. T. A. Morris and Mr. Doug. Maynard. Dr. Flowers was present with a representative of the chapter at the University of North Carolina, Mr. T. W. Fernald, Dr. Jacob A. Shuford, Commissioner on Advisory and Study, was present. Mrs. Boutwell of the Executive

Office was present in place of Mr. James T. Barnes.

The first matter of business taken up was the organization of a Section of Student AMA Chapters in North Carolina for our state meeting. It was decided that a chairman and vice-chairman be elected each year and that these two officers be elected from the same chapter, to be rotated alphabetically. Therefore, it was decided that Carolina would elect the chairman and secretary of the Section this year, the following year they would come from Duke, the third year from Wake Forest and the fourth year starting again at the University of North Carolina. We also decided that a first vice-chairman, consisting of a junior medical student, would be elected from Duke University, with the understanding that the first vice-chairman would automatically rise to be the chairman the following year. In addition, it was decided that a second vice-chairman would be elected from the other chapter and that the chairman, first vice-chairman, second vice-chairman and secretary would consist of an executive committee which would represent the three chapters of the Student AMA in North Carolina. The representative of Carolina was instructed to return to his chapter and for them to elect a chairman and secretary as soon as possible and notify Mr. Barnes of the selection. He would also notify him as to who the first vice-chairman and second vice-chairman is.

The subject of transportation for senior medical students to attend our state meeting was then discussed. It was brought to the committee's attention that the Executive Committee had already recommended the expenditure of money for buses to carry senior medical students to our meeting. After a great deal of discussion, it was voted unanimously to recommend to the Executive Committee that a bus pick up the senior medical students at Duke, Carolina, and Wake Forest sometime Monday morning, the exact time to be decided by the executive secretary in coordination with the Executive Committee of the Section on Student Affairs. The buses would arrive in Asheville in time for all of them to attend part of the meeting of the House of Delegates. It was further decided that it be recommended to the Executive Committee that the State Society furnish a meal for all the senior medical students Monday evening. With this in mind, the representatives of the chapters were instructed to inform the Executive Committee of the Section, as soon as they were elected, to organize a dinner with an evening program for the Section on Student Affairs.

It was then discussed and recommended to the Executive Committee, that rooming accommodations be furnished by the Society for Monday evening for all students present. The following morning they would be able to attend scientific exhibits, commercial exhibits and some of the general session programs. At noon on Tuesday, they would attend the various Alumni Luncheons. It was unanimously voted that Mr. Barnes be instructed to try to arrange so that the Alumni Luncheon of the three schools represented; that is, Duke, Carolina, and Wake Forest, be held Tuesday noon. As soon as these arrangements have been made, the heads of each of these alumni groups will be contacted and requested to have all the senior medical students present at the state meeting attend the Alumni Luncheon at the alumni expense. After this luncheon, they will be able to attend, for a short while, whatever sectional meetings they desired, then be able to gather and be returned to their respective school by bedtime Tuesday evening.

It was then discussed and unanimously voted that the chairman and first vice-chairman be appointed as delegates to the state meeting; that these two individuals would attend the entire state medical meeing with all their expenses defrayed by the State Medical Society. It was realized that they would not have a legal vote, but they could be present at all the meetings of the House o fDelegates, at which time they would have freedom of the floor to express their opinions and would be present to answer any questions referable to student affairs in North Carolina that might come up during our

meeting.

The above meeting was then followed by dinner, and since there was no further business, was adjourned.

> /s/ Isaac E. Harris, Jr., M. D., Chairman Edgar T. Beddingfield, Jr., M. D. Elias S. Faison, M. D. John W. Nance, M. D. Charles E. Flowers, M. D. Richard T. Myers, M. D. James P. Hendrix, M. D.

COMMITTEE ON VETERANS AFFAIRS

The Committee on Veterans Affairs during the year 1958-1959 met June 12, 1958, November 20, 1958, and February 26, 1959.

The purpose of this committee is to provide better care to service-connected veter-(1) The Home Town Care Program provides medical care to the service-connected veteran by a Home Town Physician of his choice; (2) Veterans care in V. A. Hos-

pitals and Clinics is not a direct function of this committee, but we are concerned that the Veterans admitted should be service-connected and should be given priority for admission, and upon discharge, a medical summary be sent to the Home Town Physician with authorization for follow up therapy; (3) Professional relations — through the intermediary we publish and distribute the fee schedule, disperse information pertinent to changes in the program, and by direct visits to physicians, instruct the physician and their secretaries in the appropriate procedures to complete the necessary reports and billings. Through the same media we instruct the physician as to the eligibility of the veteran for the specific disability for which he is service connected and so avoid treatment and billing for illness for which the veteran is not eligible.

The Home Town Care Program was modified during the past 18 months and the following changes adopted: (1) New Fee Schedule — at the request of the V. A. in order that the North Carolina fee schedule would conform with a standard national nomenclature and code numbers. This new schedule provides differential fees to specialists meeting specified qualifications; (2) New Physicians Participating Agreements mailed out to every member of our Society, to extend to each member an opportunity to list his qualifications for specialty rating namely: (a) Board Certification, (b) Board Eligibility, or (c) Member of a National Specialty Society. It is generally agreed that the old type participating agreement would continue to be in full force and effect for those doctors not applying for specialty rating: (3) Long Term Authorizations, new report and billing procedures were instituted by the V. A. Regional Office as agreed upon in the contract beginning July 1, 1957. About 70 per cent of treatment authorizations issued are now on a long term (annual) basis and are sent from the V. A. Regional Office in Winston-Salem. Medical progress reports are sent to V. A. Office in Winston-Salem every 3 months.

Billings are sent by the physician to our intermediary, the Hospital Saving Association in Chapel Hill, North Carolina, who pays the physician.

At the end of 1958 we had 2075 participating physicians (357 had been approved for specialty rating) ;1087 received payments during the fiscal year ending June 30, 1958.

Medical Care of Non-Service-Connected Veterans in V. A. Hospitals — The policy of our State Medical Society is similar to the policy of the American Medical Associa-

tion in reference to the medical care of nonservice-connected veterans. This committee in 1957-1958 made an official inquiry through the North Carolina Congressional Representatives as to the policy in effect for hospitalization of medically solvent-non-service-connected veterans in V. A. Hospitals, particularly since there appeared to be a discrepancy between the announced policy and the practice in North Carolina V. A. Hospitals. There were 18 replies from Congressmen and Senators indicating that they were not aware that such action was taking place. Mr. Higley, then Director of the Veterans Administration, replied at the request of one of the Congressmen and the substance of his reply was that the V. A. had to care for veterans who signed that they were not able to defray costs of hospitalized illness and that this was the law as directed by Congress.

The Intermediaries Function in the Home Town Care Program: The Hospital Saving Association of Chapel Hill, North Carolina. activated the Home Town Care Program in North Carolina in 1946 at the request of the State Medical Society and the American Legion. Since about 1950 the V. A. has attempted in many ways to eliminate the intermediary as an unnecessary medium. At a meeting February 26, 1959, the V. A. further proposed to reduce the functions of the intermediary on the basis of economy. We of the Committee feel that the Medical Society needs the service of a well organized business organization to represent the physician in his transactions between the service-connected veteran and the V. A. It is this intermediary function by the Hospital Saving Association that has encouraged such a large number of our members to participate.

At a meeting in Minneapolis, Minnesota. December 1, 1958, sponsored by the American Medical Association, a conference on Veterans and Dependents Medical Care was held. After this conference and a meeting in Chicago February 7-8, 1959, the American Medical Association Committee on Federal Medical Services agreed to make a strong endorsement of the Home Town Care Program, with a particular recommendation of the merits of the intermediary system, based on the convictions that this is the best means of caring for the service-connected veteran, providing continuity of care by a physician chosen by the veteran himself. The American Medical Association Council on Medical Service has approved this stand. The Committee's endorsement will be followed by an educational program to inform the State Associations not active in this program and an

attempt to arouse their enthusiasm and interest in the program.

The intermediary program for Home Town Care exists in California, Colorado, Hawaii, Michigan, North Carolina, Oregon, South Dakota, Washington and Wisconsin.

At our last meeting February 26, 1959, we had representatives from the V. A. Central Office in Washington, D. C., the V. A. Regional Office in Winston-Salem, North Carolina, the American Medical Association Federal Medical Service Committee from Chicago, and our intermediary, the Hospital Saving Association, and of course members of our committee. We discussed the proposal by the V. A. to reduce the duties of the intermediary to the following functions: (1) Writing checks to the physicians; (2) Maintenance of a fee schedule; (3) Submit to the V. A. a list of eligible physicians; (4) Promote professional relations; and (5) Publish and distribute a brochure approved by the V. A. on the fee basis medical program and This contract other permitted activities. would remove the authority for the intermediary to review the V. A. records, physicians requests for treatment, to audit the physicians bills and the employment of a person to visit physicians in order to help them resolve problems with the V. A.

We rejected this contract. From June 1957 through June 1958 the Hospital Saving Association spent \$188,316.00 of V. A. funds; \$19.816 was retained by the Hospital Saving Association and the remainder was paid to physicians. We doubt if the V. A. assumed the duties of the Hospital Saving Asosciation that there would be any savings on the 11.6 per cent overhead by the Hospital Saving Association. The Hospital Saving Association has continued to function as an intermediary not for the profits involved, but because as the Blue Shield-Blue Cross Agency of our Society, they continue this harassing job as a service to the Medical Society. We proposed to the V. A. Central Office and to the American Medical Association that the Home Town Care Program be extended for service connected veterans beyond the treatment given the veteran in his home or in the office of his home town physician, but to try experimentally in a limited way, treatment in Home Town Hospitals limited to service-connected illness. This type of treatment could be handled by a type of insurance program for the veteran not unlike Blue Cross and Blue Shield and thus enabling the service-connected veteran to have treatment for service connected illness at home, near his family and by his own physician.

This program could be tried and limited to

a specified illness and/or to specific geographical location. It would solve the problem of ever increasing V. A. Hospital beds. Give the service connected veteran an advantage that the non-service-connected veteran would not have, of either going to a V. A. Hospital or remaining at home near his family and friends. Remove the stigma from the serviceconnected veteran of being a ward of the State, etc. The cost need not exceed medical care in a V. A. Hospital (including costs of transportation, building construction and maintenance, etc.) and duration of hospital stay, and the program could be carried out by the V. A. or a private insurance carrier. The State Medical Society members and our intermediary would cooperate fully to educate the physician and hospitals that the service-connected veteran was eligible only for care of the service-connected disability. The service organizations could educate the service-connected veteran of this special privilege over and above his non-service-connected brethren.

/s/ S. L. Elfmon, Chairman

REPORT FROM THE HOSPITAL CARE ASSOCIATION TO THE HOUSE OF DELEGATES OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

In May 1958 the Medical Society elected four physicians to the Board of Directors of the Hospital Care Association. The Board of Directors of the Hospital Care Association is composed of twelve members: four elected by the North Carolina Care Association, four public representatives elected by the members of the Association, and four physicians elected by the Medical Society of the State of North Carolina.

The four directors elected by the Medical Society of the State of North Carolina accepted their positions and immediately began attending Directors meetings, which are held at the home office of the Association in Durham on the fourth Tuesday of each month. This report covering general progress of the Association in 1958 also contains information which is believed will be of interest to both the House of Delegates and the full membership of the Medical Society.

Membership

As of December 31, 1958, membership in the Hospital Care Association was 323,988 with 313,893 of these members having both hospitalization and surgical benefits. Many of the persons with hospitalization and surgical benefits also have in-hospital medical benefits. Some also have either Extended

Benefits, Major Medical, or a Dread Disease Endorsement.

The financial condition of the Association as of December 31, 1958, was as follows:

ASSETS \$4.807,291.76 LIABILITIES 2,258,129.82 RESERVE 2,549,161.94

BENEFITS PAID TO HOSPITALS

and PHYSICIANS IN 1958 7,154,228.65 The total amount paid by the Hospital Care Association to hospitals and physicians since it was chartered in 1933 now exceeds \$50,000,000. The Association has been constantly increasing its schedules of benefits and broadening its scope of services until at the present time it offers: (a) A comprehensive certificate on a bed and board allowance up to \$15 a day, with certificates providing either 70 or 120 days of care per confinement: (b) Five surgical schedules ranging up to a \$300 maximum (97 per cent of all members have both hospital and surgical benefits); (c) Hospital-medical program of benefits which includes a wide range of in-hospital medical payments.

Endorsements

The Hospital Care Association offers a wide range of benefits in the form of endorsements to its basic certificates. They include guarantee of semi-private accommodations, out-patient x-ray and laboratory, extended benefits (\$10,000 maximum), major medical (\$10,000 maximum), and dread disease (\$7,500 maximum).

Rural Enrollment and Nongroup Enrollment Rural Enrollment and Nongroup Enrollment

The Association during 1958 greatly increased its activities in enrollment of Farm Bureau members, Farmers Federation members, and rural community development organizations. To help reach these rural people, the Association put into operation during the year a new mobile enrollment office. This trailer will tour the smaller towns throughout North Carolina, on a year-round basis. Doctors and hospitals are helping a great deal in this non-group enrollment program.

Hospital Care Association has endeavored to provide the people with what they want, need, and can afford. It is continuing to work toward expansion of benefits and is ever seeking ways and means to get these benefits to the uncovered segments of our population—the unemployed, the aged, and the medically indigent.

Nineteen-hundred and fifty-eight marked the twenty-fifth anniversary of the Hospital Care Association. At a dinner commemorating this important milestone the Blue Cross Commission of the American Hospital Association presented to the Association a citation for its fine service rendered to the people of North Carolina. We feel that this citation is well deserved.

We have thoroughly enjoyed attending the monthly meetings of the Board of Directors of the Hospital Care Association. We have tried to familiarize ourselves with its operating procedures. We consider that the Plan is well directed by its Board and is a service organization worthy of the high regard in which it is held. We feel that the Association is making a fine contribution toward the solution of one of our major health problems in North Carolina.

In May 1958 the House of Delegates of the Medical Society voed to approve the Hospital Medical Society voted to approve the Hospital the same terms and bases with the Hospital Saving Association. The Association was subsequently advised by the Medical Society that in order to be granted Blue Shield approval the four public representatives on its Board must be elected by the eight other members of the Board, which include four hospital representatives and four physicians elected by the Medical Society.

The Board of Directors of the Hospital Care Association expressed the feeling that the hospitals, the Medical Society, and the membership of the Association should each have full and equal voice in the Board of Directors. The Board of Directors felt that the membership of the Hospital Care Association should have the right to elect the four public representatives, and, further. the Board felt that any portion of its Board elected by any other portion would not feel that it had equal voice in the management of the Association. In view of this, the Board of Directors of the Hospital Care Association voted unanimously to continue its present Board structure, which provides for the election of its public representatives by the membership of the Association at the annual meeting. This arrangement, which gives physicians, hospitals, and the membership equal authority in the affairs of the Association, is considered an ideal structure for a nonprofit hospital and medical service plan.

The physician Directors of the Hospital Care Association regret that due to this difference in method of electing public representatives, the Hospital Care Association was not granted Blue Shield approval by the Executive Committee of the Medical Society of the State of North Carolina.

The physician Directors of the Association hope the Medical Society will reconsider the action taken and find the Board structure of the Hospital Care Association entirely acceptable for Blue Shield approval.

/s/ J. Street Brewer, M. D., Chairman Alfred T. Hamilton, M. D. Willard C. Goley, M. D. Charles T. Wilkinson, M. D.

SPEAKER KOONCE: At this time I would like to call on Dr. Rousseau to make a few remarks.

DR. ROUSSEAU: Mr. Speaker and members of the House: I believe the motion we passed this morning was not actually understood in regard to the A.M.A.'s proposal with reference to physicians' reducing their fees to the worthy and poor patient. That did not mean that you passed any motion to reduce fees to any welfare people. You are giving your services away to the indigent and to charity without any complaint all the time. You have always done so and will continue to reduce your fees to the less wealthy and the less fortunate patient.

I would just simply re-emphasize that this is a positive program. I would like to have something that our Congressmen and Senators will listen to. I believe they will immediately say, what is the use of the government legislating any more on the medical care programs when the physicians of the United States are doing this anyhow.

I would like to suggest that those who are dissatisfied with the motion find out more about it and let's put up a united front and not go home and let the public feel that we voted for something we did not like. Let's put up a united front and put this program across. That is my one plea to you, and I hope you will bear that in mind. Thank you very much!

SPEAKER KOONCE: Dr. Fergurson, do you have something you want to say?

DR. FERGURSON: Mr. Speaker, there was one point of clarification which I feel necessary to complete the comments which I made. I wish to request permission to incorporate this in my remarks this morning:

"It is further suggested that the indigent continue to be care for gratis by the local

doctors."

These needs certainly could be adequately established, more adequately established, at the local level in cooperation with the local welfare department. This would also act as a deterrent against the unnecessary hospitalization of the older age groups. The doctor will continue to be respected and appreciated for his age-old privilege of personally treating the poor without thought of remuneration. I just wanted to clarify that point.

SPEAKER KOONCE: We accept that as

information, and that is in the minutes, Dr. Fergurson.

Now we come to New Business.

MR. BARNES: I have here a communication from Dr. Charles G. Tabor who at that time had left Franklin County and was undergoing orientation for foreign mission medical work for the Southern Baptist Convention. He expressed some concern about his ability to continue his membership. For your information, under the privisions of the By-Laws, I have a letter from the Franklin County Medical Society. A man engaged in foreign mission work could by election by the House of Delegates be made an honorary member of the Society during the time of such foreign mission medical service.

As a consequence, the Secretary of the Franklin County Medical Society secured from the Foreign Mission Board a certification about Charles Gordon Tabor, that he was assigned to work in Korea and he would be after the fall of 1959 in Pusan, Korea. That has been confirmd, and this matter is brought to your attention for possible action in making him an honorary member of the State Medical Society for the period of his

foreign mission service.

DR. SAMS: Mr. Speaker, I move that we elect Dr. Tabor as an honorary member of this Society so long as he serves as a missionary.

(The motion was seconded, was put to a vote and carried.)

SPEAKER KOONCE: A resolution on Dr. Dixon:

Whereas, Dr. G. Grady Dixon was a long and useful member of the Medical Society of the State of North Carolina, exemplifying the finest of personal qualities in manifesting a responsibility for public service to his patients, and,

Whereas, he had lent distinction and service to the Medical Society of the State of North Carolina as a leader, as an officer and as a representative of the Society upon other organizational structures and

programs, and

Whereas, he exemplified concern for the problem of medicine and loyalty to the professional organizations which implemented such concern of the Medical profession, even to the last hours of his life during the course of the 1958 Annual Sessions of the Medical Society of the State of North Carolina, now therefore be it

RESOVED that this House of Delegates record for posterity the high regard of his fellow physicians and organizational leaders in North Carolina medicine in profound appreciation for the contributions

which he has made to the profession of medicine and to this Society, and be it

FURTHER RESOLVED that a copy of this resolution be spread upon the proceedings of this Society and that a copy be sent to the surviving members of his family and for the records of the North Carolina State Board of Health upon which he served long and dutifully and finally as its President.

Do I hear any action as far as that resolu-

tion is concerned?

DR. STROSNIDER: I move the adoption of the resolution.

(The motion was seconded, was put to a vote and carried.)

SPEAKER KOONCE: Another resolution:

Whereas, the Medical Society of the State of North Carolina in its preface and premise of organizational purposes places the matter of the public health high upon its list of objectives, and

Whereas, the Medical Society of the State of North Carolina has persisted in seeking to influence sound legislation designed to promote and safeguard the public health of the people of the State, and Whereas, this Society has found statesman-like understanding of the problems of medicine and public health in the services of the distinguished Dr. David Rose, representing the Eighth Senatorial District in the North Carolina General Assembly, therefore be it.

RESOLVED that the Medical Society of the State of North Carolina here express its marked appreciation for the interest, cooperation and statesmanship of Dr. David Rose in connection with his accomplishments for medicine and the public health through the course of his several terms of service in the Senate of the North Carolina General Assembly, and be it

FURTHER RESOLVED that a copy of this resolution be dispatched by the officials of the Medical Society of the State of North Carolina to the President of the Senate of the North Carolina General Assembly and to Dr. David Rose.

Do I hear a motion concerning this resolution?

DR. KERNODLE: I move its adoption. (The motion was seconded. Discussion was called for. There being no discussion. the motion was put to a vote and carried.)

SPEAKER KOONCE: Another resolu-

tion:

Whereas, the Medical Society of the State of North Carolina recognize dis-

tinction in service to medicine and to the public health on the part of Dr. Rachel Darden Davis, representative of Lenoir County in the House of Representatives of the North Carolina General Assembly and of Dr. John Phelps, representative of Washington County in the House of Representatives of the North Carolina General Assembly, therefore be it

RESOLVED by the Medical Society of the State of North Carolina that this expression of appreciation be dispatched to Dr. Rachel Darden Davis and to Dr. John

Phelps.

DR. SAMS: Mr. Speaker, I would like to move that we adopt this resolution and inform this House of Delegates that it was my privilege to be in the 1951 Assembly and do the things that they are doing.

(The motion was seconded, was put to a

vote and carried.)

SPEAKER KOONCE: Mecklenburg has a resolution. Would you care to present it, Dr. Faison?

DR. FAISON: Mr. Speaker and members of the House of Delegates: This is a resolution concerning the possible change in the meeting dates of the Medical Society of the State of North Carolina:

Whereas, medical trends have changed a great deal during the past few decades,

Whereas, it is practically impossible to secure a sufficient number of rooms for our membership during the first part of the week, and

Whereas, this problem could be greatly avoided by changing the meeting dates from the first of the week to the latter

part of the week, and

Whereas, it would be a distinct advantage to our Society to rotate the meetings between certain cities or geographic localities, and

Whereas, such an arrangement would in all likelihood increase our attendance

and registration, now be it

RESOLVED that this House of Delegates go on record as approving a change of meeting time from the first of the week to the latter part of the week.

Mr. Speaker, may I have a minute or two

to speak on this resolution?

As to the first "Whereas," we believe when we say that medical trends have changed, that the majority of the doctors in this State now are out of their offices on Saturday afternoon, whereas it used to be that doctors were on duty Saturday afternoons.

As for the statement that it is impossible to secure a sufficient number of rooms the

first part of the week, we have talked with the different hotel managers of large hotels throughout the State, of course not including Asheville because we can meet here quite satisfactorily, and they tell us that the first part of the week is the part of the week in which they have very heavy commitments to travelling men, and so forth, and they cannot allocate rooms to conventions. The latter part of the week hotels have no registrations to speak of, and they would be glad to have us.

On that score, in Charlotte the different hotel managers tell us there are from 1.500 to 1,700 rooms available at the end of the week, and all rooms available that were polled throughout the State are hotels and

motels of class A type.

In Greensboro there are 1,200 to 1,350. Of course, you understand we would not have all of these rooms. We believe in Charlotte that the number of rooms is adequate. In Raleigh there are from 1,200 to 1,400

Our County Society believes that to have good organized medicine we ought to have good registration at our State meetings. We believe if our suggestion is followed that

registration will go up.

I want to make it clear that we want the best in our County for organized medicine, and we bring this resolution to find out if it is better for our registration, if it is better for organized medicine, if it is better for our State Society, to hold meetings the first part of the week. If we are right in what we say, then I want you to know that we are 100 per cent in accord in saying that that is the time to hold the meetings. If registration, on the other hand, is better at the end of the week, then we are in favor of that. Therefore we brought this resolution to you to sort of clear the atmosphere.

If this thing was set up years ago to meet the first part of the week and conditions have changed, then it is high time that we changed. If it is wrong we ought to continue

meeting as we are.

I move that this resolution be passed.

(The motion was seconded.)

SPEAKER KOONCE: For your information, I would like to state that the Executive Council went on record as disapproving this recommendation.

DR. SAMS: You just took the words out of my mouth. I am speaking as a small-town doctor to you. Most of the people in my county come to town on Saturday. Saturday is worth more to me in my office than the other five days in the week. However, I don't think we ought to let each city tell us what to do.

SPEAKER KOONCE: Is there any further discussion?

PRESIDENT BAKER: This came before our Council, and we disapproved it, recognizing all its good points. After all, if we are going to meet on th weekend that would mean your officers would have to be here Tuesday for the Council meeting and Wednesday. Thursday we would have to have rooms, and, after all, on Thursday we would have trouble getting rooms in the hotels just as much as we are having otherwise. So we only have Friday and Saturday that is easy. What will be do with Thursday if we change? We would have the same situation. These travelling men are still in there on Thursday night.

SPEAKER KOONCE: Is there any further discussion? If not, are you ready for

the question?

(The motion was put to a vote and lost.) SPEAKER KOONCE: Is there any new business to come up from the floor?

DR. WILLIAM P. RICHARDSON (Durham-Orange): Last year the delegates from Durham-Orange Medical Society came expressly to present a request to the House of Delegates which the circumstances of that meeting prevented our presenting. At its meeting last month the Society reviewed that request, and so I should like to present it at this time. It is that the President appoint a committee to study at the State level the problem of Social Security for physicians or the problems of physicians being included under the Social Security Act.

This grew out of the action of our own Social Security Committee which, for the benefit of any of you who may be thinking that this is a Society of a large number of active members of the two medical schools, was chaired by members who are in the private practice of medicine and not members of the faculty of the two medical schools.

I should like to move on behalf of the Durham-Orange Medical Society that the President be requested to appoint a committee to study at the State level and to determine the sentiment of the State in regard to federal Social Security.

(The motion was seconded.)

SPEAKER KOONCE: We are trying our best to cut down on extra committees. Every time we come to a meeting of the House of Delegates there are usually ten or more committees suggested. We have tried awfully hard in the last few years to cut them down. This will be assigned to a committee existing or if necessary we will appoint a new committee.

If someone on the floor should add an amendment to your motion, I wonder if you would accept it, that the President be authorized to appoint that committee at an opportune time. The reason we say that is that your Council discussed this same matter. We are aware of the need for this, but we thought any official action that we took at this time along such lines would weaken our move towards the Keogh-Simpson Bill. We thought we should wait at least until this present Congress is over with to see if we get a favorable reaction to the Keogh Bill. If someone will make such an amendment or you would amend it yourself, I think this would be a wise thing to do.

DR. RICHARDSON: I think that expression is implicit in the fact that this is a request and not an instruction.

SPEAKER KOONCE: I think that settles that. Is there any further discussion of this motion?

(The motion was put to a vote and carried.)

SPEAKER KOONCE: It there any further new business? If there is no further new business, the next thing that comes up is selection of representatives to the Medical Care Commission, the Hospital Saving Association, the Hospital Care Association. According to the rules and regulations it has to be done by ballot. Therefore we will have to take a little time and to get through as fast as we can. You will get ballots to vote with and we will have to vote on each one. The floor is open to nominations for the Medical Care Commission which at the present time is held by Dr. Coppridge.

DR. SAMS: Mr. Speaker, we were informed in the Executive Council that Dr. Coppridge has asked not to be re-elected. Mr. Speaker, I am getting along in years, and I like the idea of putting younger men in these places. I therefore rise to nominate a man who is in Raleigh, who is a young man, active, and is a very fine doctor. I refer to Dr. P. G. Fox.

DR. SMITH: I move that nominations be

closed.

(The motion was seconded, was put to a vote and carried.)

SPEAKER KOONCE: I don't think a ballot is necessary under those circumstances since there is only one nominated.

Next is a member of the Hospital Saving Association Board, the place being held at the present time by Dr. Pace.

DR. BONNER: Dr. Carl Pace whose term expires this year. I am asking the House of

Delegates to re-elect Dr. Pace to succeed himself. Dr. Pace has served this Society long and well. He has had a great deal of experience in the Insurance Committee, the Hospital Saving Board and Blue Shield Committees, and I think he would make a splendid member because of his experience. I am going to ask you to re-elect him to succeed himself.

DR. STROSNIDER: I would like to second the nomination of Dr. Carl Pace to succeed himself.

DR. BRADLEY (Buncombe: I move that nominations be closed.

(The motion was seconded, was put to a vote and carried.)

SPEAKER KOONCE: The next is a member to the Hospital Care Association Board, a post now held by Dr. Goley.

DR. KERNODLE: Mr. Speaker, I would like to nominate Dr. Willard Goley for an additional four-year term as trustee for the Hospital Care Association.

SPEAKER KOONCE: Are there any further nominations from the floor?

DR. SAMS: I move that nominations be closed.

(The motion was seconded, was put to

a vote and carried.)

DR. SMITH (Guilford): From long experience with our insurance program, I have become convinced that the competition between the two Blue Cross Plans largely explains the lack of interest on the part of many doctors. This Society had a committee for many years to effect a merger of these two institutions. They finally gave it up and it was allowed to expire. It seems to me that now that we are appointing one trustee to each of these institutions each year it is time for us to start appointing the same man to both positions and thereby bring these two organizations together. With that in mind I would like to make a motion that beginning next year we appoint the same man as trustee to both institutions,

SPEAKER KOONCE: Is there second to the motion?

(The motion was seconded.)

SPEAKER KOONCE: I would like to bring up that your motion, Dr. Smith, would require a change in the By-Laws, and would therefore have to go through the By-Laws Committee and be held over from one meeting of the House of Delegates to another.

DR. SMITH: I will repeat the motion and suggest that it be referred to the Committee on Constitution and By-Laws with instructions to carry it through. How would

it get there otherwise?

SPEAKER KOONCE: That clears that. The motion is still on the floor. Is there any further discussion?

(The motion was put to a voice vote.)

(Anent action next above see modifying

action of May 5, 1959. Ed.) SPEAKER KOONCE: The Chair is in doubt. Those who are in favor please stand. Thank you. Be seated. Those opposed please stand. The motion is carried.

The Nominating Committee has appointed Dr. Hubert Poteat as Chairman, and Dr.

D. E. Ward, Jr., as Secretary.

Unless there is any further business, I am going to ask for adjournment with one announcement. Please look on your schedule and see that the second meeting of the House of Delegates is at two-thirty tomorrow afternoon instead of Wednesday afternoon, and will be held in the East Ballroom of the George Vanderbilt Hotel rather than in here.

(The meeting adjourned at five-thirty

o'clock.)

TUESDAY AFTERNOON SESSION May 5, 1959

The second session of the House of Delegates convened at two-thirty o'clock, Speaker Koonce presiding.

SPEAKER KOONCE: We will get started on this second session of the House of Dele-

gates. The first thing that we have to bring up I hope will be just a technicality. A mistake unwittingly was made yesterday in the report of the Nominating Committee. In the Second District last year Dr. Brooks was re-elected as councilor and Dr. Bell from New Bern was elected as Vice Councilor. Soon thereafter Dr. Brooks resigned and Dr. Bell was appointed Councilor by the Executive Committee in September.

As well as I can see there is nothing specific about that in the By-Laws, but by custom the Executive Council has had the right to appoint the Vice Councilor to take the place of the Councilor in the case of

death or resignation.

Inadvertently and unwittingly the Nominating Committee apparently-I am simply going on the assumption—took for granted that the appointment of Dr. Bell was simply for the duration of the year to the present House of Delegates meeting and they nominated Dr. Lynwood Earl Williams of Kinston for the Second District Councilor, and that was passed yesterday by this body.

As a simple technicality the Chair is going to rule that that action of the Nominating Committee was unconstitutional and that Dr. Bell is still Councilor of the Second District. I would like to have a motion from the floor affirming the action of the Chair.

DR. ROSCOE McMILLAN: I move that the ruling of the Speaker be approved.

(The motion was seconded.)

SPEAKER KOONCE: Is there any discussion?

(The motion was put to a vote and car-

ried.)

SPEAKER KOONCE: Again taking the prerogative of the Chair, which I am not accustomed to do but I got into the habit of it yesterday, the Chair feels that the Vice Councilor as elected yesterday should stand. Do I have a motion to affirm that?

DR. McMILLAN: Mr. Speaker, I so move. (The motion was seconded by Dr. Rous-

SPEAKER KOONCE: Is there any discussion of the motion?

(The motion was put to a vote and car-

SPEAKER KOONCE: So we got out of that without any trouble. That seemed a bit

tricky.

DR. PEELE (Lenoir): I hoped to get this thing straightened out. Everything was all fouled up in the Second District. idea was to have Dr. Williams elected as Vice Councilor this year. In the mix-up he was nominated as Councilor and Dr. Larkin as Vice Councilor. I don't know how we are going to get it straightened out. That was the wish of the District.

SPEAKER KOONCE: The action has been taken, but of course it can be rescinded and the ruling of the Chair can be overruled, is

that right?

DR. ROYAL (Carteret): Could this complication be put into the lap of the Executive Committee for settlement? I so move.

SPEAKER KOONCE: Dr. Royal has made a motion that Dr. Bell remain as Councilor and that the matter of the Vice Councilor be put in the hands of the Executive Committee.

(The motion was seconded by President Baker.)

SPEAKER KOONCE: I am a little confused as to whether that motion will take precedence over that action which has been taken by the House of Delegates. According to Dr. McMillan, and I cannot help but agree with him, it cannot take precedence.

DR. PATRICK (Lenoir): Didn't Council already act, Mr. Chairman? I believe that in the minutes of the Executive Council this matter of appointing Dr. Williams as a Vice Councilor has already transspired.

SPEAKER KOONCE: Dr. Patrick is ab-

solutely right, and the Chair was entirely out of order in his ruling that Dr. Larkin be made Vice Councilor. The Chair would like to make a second ruling, that the stand of the Executive Committee taken in September be affirmed, and that was Dr. Bell as Councilor, Dr. Williams as Vice Councilor. Can I call for a vote on a motion to that effect?

PRESIDENT BAKER: I am sorry to get in late. I don't know what transpired in this meeting before I got here. Maybe you already spoken for the Council. Has it been made clear, or do I need correction on this, that the action of the Executive Council of the Medical Society of the State of North Carolina at their meeting was to make Dr. Bell the Councilor and Dr. Williams the Vice Councilor and that that only held until the next meeting of the House of Delegates of the Medical Society of North Carolina? As for anything beyond that, we were not appointing anyone to fill out an unexpired term. We were appointing someone to fill the office until the next meeting of this House of Delegates. I think that should be made clear. I think our minutes will show that your Council has only one authority and that is to act for the House of Delegates until the next meeting of the House of Delegates.

This Constitution we changed yesterday that Dr. McMillan is speaking of has nothing to do with what we are talking about. This all took place previous to this change. Dr. Bell, by your Executive Council of which I was Chairman, was made representative of the Second District until the next meeting of the House of Delegates, and Dr. Williams was made the Vice Councilor until the next meeting of the House of Delegates, and we had no other force beyond that meeting.

We came back at this meeting and we have had an election. I have no personal desire whatever as to what we shall do about this, but I think it must be legal, and I am not certain that we can now go back and change what was legal. What we did in the Council has nothing to do with what this House of Delegates does. If I am wrong I will apologize, but I think we should be clear.

DR. PEELE (Lenoir): This is exactly the understanding that the Nominationg Committee had. It was the understanding of the Second District meeting that the situation is just as Dr. Baker has outlined. We received instructions from the State office to nominate a Councilor and Vice Councilor for the Second District, and that is what we did, and I can affirm what he has just told

vou.

SPEAKER KOONCE: My understanding is that by custom, not by the By-Laws, since there is nothing in the By-Laws on the subject and I looked through them last night and this morning when the question came up, the Executive Committee has the right to appoint a successor to a Councilor in case of death or resignation, and it is my understanding that the successor was appointed in September to fill the term rather than until the present House of Delegates. That is not Dr. Baker's understanding.

I don't know exactly what action to take I thought I had this thing all straightened out. The Chair could take action and ask affirmation of that action and that would settle it because the members of the Second District who have contacted me were un-

happy with the action of yesterday.

DR. ROYAL: The only thing I had to say was to make my motion a little bit more all-inclusive. My motion formerly was that the unsettled portion, so to speak, of yesterday's action be put in the hands of the Executive Council for settlement, but it seems it is all unsettled, and in that event I move that the whole matter be put, in the interest of conservation of time and a satisfactory settlement, in the hands of the Executive Council and that their action be final.

SPEAKER KOONCE: I am going to take the prerogative of the Chair again, which has just got me into a lot of trouble, and ask Dr. Royal if he will make a motion that the action of the Speaker was unconstittnional and the Nominating Committee report remain as it was, because that is the understanding which I have been corrected to, that the Executive Committee took the stand purely and simply until the House of Delegates met. The Nominating Committee made a nomination, it went through, and it stands as it is. I would like Dr. Royal to declare that the Chair's action is unconstitutional and the Nominating Committee's report remains as it is.

DR. ROYAL: I will ask someone else to make that motion because, frankly, I don't think it is unconstittuional.

SPEAKER KOONCE: We are really getting into a hassle here. I still would like somebody from the floor to make that motion.

DR. BONNER: I make that motion.

(The motion was seconded by Dr. Shuford.)

(Discussion was called for. There being no further discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: In other words, as

it stands now, the action of your Speaker was unconstitutional rather than the action of the Nominating Committee, and Dr. Williams is Councilor of the Second District.

The next order of busines is a little bit more pleasant than the last one. The next item is a carry-over from yesterday, the introduction of the Practitioner of the Year, Dr. Fortune. We will ask Dr. Fortune to say a few words.

DR. FORTUNE: Mr. Chairman and Members of the Medical Society, Ladies and Gentlemen: The vast majority of you who are slightly younger than I cannot possible realize what this great honor means to me. To be counted among our fellow physicians is a privilege in itself. Little did I realize when I was selected by my own County Society that I would be so singularly honored by

I know that many of you present today are better qualified than I am, so it is with a feeling of humility and gratitude that I want to thank you from the bottom of my

heart. (Applause)

PRESIDENT BAKER: Dr. Fortune, as the outgoing President of the Medical Society, I know of no honor a man would rather have than this. To be picked as a man who is outstanding as the backbone of medicine as the General Practitioner of his County would be the greatest recognition I could receive. As a specialist, I could never have it, but I congratulate you on having gotten it. (Applause)

SPEAKER KOONCE: The next item is ratification of the By-Laws which were brought up yesterday. Dr. Roscoe McMillan!

DR. McMILLAN: Mr. Speaker, Mr. President, Members of the House of Delegates: I don't have to read all this again, do I, Jim?

MR. BARNES: Just by title.

DR. McMILLAN: Reading by title, from the itemized agenda in the By-Laws, Chapter XII, Section 1 was amended and passed at yesterday's meeting of the House of Delegates. I move that this be adopted at this meeting, Mr. Speaker.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: Mr. Speaker, Chatham County getting into another section, striking out from Chapter VII, Section 1, the word "Chatham." I move the adoption of this amendment.

(The motion was seconded, was put to a vote and carried.)

DR. McMILLAN: An action was passed yesterday, and it relates to Chapter VII, Section 1, which doesn't amount to very much, but we have got to ratify it. I move the adoption of this amendment.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: An action was passed yesterday, and it relates to Chapter VII. Section 1, which doesn't amount to very much, but we have got to ratify it. I move the adoption of this amendment.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: I move the adoption of this amendment, Mr. Speaker. It relates to Chapter X, Section 1.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: I move the adoption of the amendment which relates to Chapter XV, Section 12. I move the adoption of this amendment.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: Mr. Speaker, I move the adoption of amendment. Chapter XV. Section 3.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: I move the adoption of amending Chapter XII, Section 1.

(The motion was seconded, was put to a

vote and carried.)

DR. McM1LLAN: Mr. Speaker, I move the adoption of amendment which is to amend Chapter X, Section 7.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: Mr. Speaker, I move the adoption of amendment Chapter X, Section 19.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: Mr. Speaker, I have one that was handed to me today. It relates to Chapter XI, Section 1, and deals with the provision for a Chairman-Elect of the section. I move this amendment.

(The motion was seconded, was put to a

vote and carried.)

DR. McMILLAN: One other was handed to me today, that is to add a new sentence to section 14, chapter IV, at the end of the section after the word "floor" as follows: "The same member will be elected to serve on the Board of Trustees of both the Hospital Saving Association and the Hospital Care Association."

This was a resolution introduced, I believe, by Dr. Norris Smith yesterday, and I move the adoption of this. We will reword this if it is agreeable to you to fit in the format. I have not had time to look this up. That is one reason I was a little confused. Dr. Smith, did you intend this to go in this year or next year?

DR. SMITH: Next year. I would like to speak on that. I have had a number of questions asked me about it.

As most of you know, I have been on the Blue Shield Committee for some eight years except this past year. I am in Columbus now. I have long been convinced that our insurance program in North Carolina and our Blue Cross program in particular has been crippled by this needless competition between two Blue Cross companies, and I might again point out to you that this is the only section of the United States where such competition exists. The Blue Cross Commission itself has been very much disturbed by it but they are powerless to do anything about it.

In all of our insurance problems we have faced in the last twelve years, the element of competition between Hospital Care on the one hand and Hospital Saving on the other has entered our deliberations in this hall. The hospitals are taking advantage of the competition between the two companies by playing one against the other. Each company has overreached itself in the programs that they are selling, offering such things as free X-rays which should have been long since curtailed, the things which are promoting the abuse and as a result of which in North Carolina we are having an admission rate of about 170 patients per thousand per The National Blue Cross averages year. about 140.

The competition has been cut-throat with regard to selling. One company is going in and cutting the throat of the other. It has been costly to both of thm. There is tremendous duplication of cost in overhead between the companies, not only in the expensive IBM machines that each has got to maintain and where one set of them could handle all of these accounts, but more importantly it has diverted the doctors' attention from the principles of Blue Cross and Blue Shield. Each has been engaged in selling you and other doctors on the advantages of their particular association. There are costly billboards all over the State competing between them which the subscriber is paying for. Both of them are running overhead in the neighborhood of 9 to 11 per cent, and it used to be considerably more, whereas the larger companies in other States where their business is a greater volume are down to less than 4 per cent.

I point out all of these things to show you that this is one field where competition is harmful.

Lenox Baker has bedeviled me for years when I got up here on this matter before because he would stand up and say, "Well believe in competition." I am told by reliable sources that Lenox told the Executive Council the day before yesterday that he was convinced that competition was not good in this field. I hope he is here to make his own statement. But this is a field where we need to be unified, where these policies need to be improved for the benefit of the patient. This is a field where we are appointing our members to serve on the Board of Trustees to bring about the improvement and the best utilization and the better sale of Blue Cross and Blue Shield insurance for the benefit of the people of North Carolina, The commercial insurance companies in this state have outsold Blue Cross, and they will continue to do so as long as we let the two companies scrap and cut each other's throats.

This Society about 1937 appointed a committee which proved to be a standing committee for some ten or twelve years, and it was called the Committee to Effect the Merger of Hospital Saving and Hospital Care Associations. I recall that George Carrington of Burlington was a long-time Chairman and Arthur London of Durham was a long-time Chairman. I have heard Arthur speak very bitterly of the stone wall that they ran into in trying to effect any compromise.

This competition is doing a lot of harm. We are now in a position of electing Trustees on each of the two Boards where we can bring these two units closer together. It is chiefly through one individual who is prominent in the affairs of one company that has kept them apart. This individual, by means of proxies from their subscribers in a large group sale, can walk into the annual meeting and in effect appoint four lay trustees that are presumably to represent to stockholders.

My plan is simply this—during the next four years at each annual meeting we will elect one trustee to serve on both Boards. I am told that both Boards meet on the same day by chance, one in the afternoon and one at night, so it would not be too great a burden. I would admit that two different meetings each month would be a great burden. We have many able men who have cut their eye teeth on this health insurance program through the Blue Shield Committee that are available to fill in. Some are uncertain about the wisdom of our appointing men to this position who have been indoctrinated so to speak by previous service on one or the other, but there will be three good men coming off of the Blue Shield Committee

lext year that would make excellent candilates. However, if in the next four years we can place four men on each of these two Boards of Trustees it is bound to result in tending to bring them closer together in heir commonly meeting some of these probems that urgently need to be met and evenually in merging these two organizations unler some new name.

I am not a stickler for names, but we need one Blue Cross and one Blue Shield in North Carolina that we doctors can get be-

ind.

SPEAKER KOONCE: I know things went oo smoothly yesterday. From my recollection, I have not been right yet, so I am probably wrong this time, too. My recollection yesterday was that Dr. Smith made a notion that the member of these two Boards be the same. He was declared unconstitutional because it would mean a change of By-Laws. If I remember correctly, he amended it that it be referred to the Committee on Constitution and By-Laws to be taken up by the Executive Council for consideration and to be brought back.

Now my feeling is, according to the action that was taken yesterday, that that should be brought up by the Committee on Constitution and By-Laws to be studied thoroughly by the Executive Committee and brought back to us next year. That is my feeling and understanding. Dr. Smith, do you have any

objection to that?

DR. SMITH: The Constitution and By-Laws allows the revision of the By-Laws by action taken by the first and second meeting

of the House of Delegates.

SPEAKER KOONCE: That is perfectly true, Dr. Smith, but according to your motion the way it was read yesterday, it was to be referred to that Committee and the Executive Committee.

DR. SMITH: It was referred to the Committee on Constitution and By-Laws for proper wording, but it would not take effect until next year. We have already elected the

two Trustees this year.

SPEAKER KOONCE: My personal feeling, which I have no right to express but I will anyhow, is that this should be referred to the Executive Committee and the By-Laws Committee to be studied more thoroughly and brought back nevt year.

According to Mr. Barnes, and it is the way I understand it also, even if this is passed today it would have to be ratified

next year.

DR. SMITH: I would like to ask Mr. Anderson's opinion on that. As a revision of the By-Laws, it is not simply a matter

of bringing it before us at two sessions twenty-four hours apart?

SPEAKER KOONCE: Your request yesterday was not to revise the By-Laws but for the By-Laws Committee to take it up.

DR. SMITH: It was for the By-Laws

Committee to reword it properly.

SPEAKER KOONCE: The By-Laws Committee would have had to make a report yesterday to have had it ratified today. They did not make a report on that. Therefore it cannot be acted on today. It would have to be acted on next year.

DR. SMITH: I would like to ask Mr. An-

derson's opinion on that.

MR. ANDERSON: If the action yesterday constitutes a resolution to refer the matter to the By-Laws Committee for proper wording, it does not constitute an amendment to the By-Laws. Therefore today would be the first time you would vote on an amendment and it would not become effective until it had been voted on at a second meeting of this House which would be held sometime during the coming year or next year.

SPEAKER KOONCE: Thank God somebody agrees with me. According to that, I am going to ask the By-Laws Committee if they will present that as a change in the By-Laws at the present time to be ratified

next year and we will vote on it.

DR. MMcILLAN: Mr. Speaker, this resolution is that the same member will be elected to serve on the Board of Trustees of both the Hospital Saving and the Hospital Care Association. I so move.

SPEAKER KOONCE: Then that is a motion which has been made by the By-Laws Committee at the present time. Do I hear a

second to the motion?

(The motion was seconded. Further discussion ensued.)

DR. KERNODLE: Mr. Chairman, in view of the discussion that has preceded me I would certainly agree that there is not enough known about which is best in adopting the purports of this amendment. Therefore I would like to make a substitute motion that this be referred to the By-Laws Committee and thoroughly discussed and brought back to us by the Executive Council.

(The motion was seconded.)

SPEAKER KOONCE: There has been a substitute motion, and the motion has been seconded. If there is no further discussion, we will vote on the substitute motion.

(The substitute motion was put to a vote and carried.)

PRESIDENT KOONCE: So be it, and the matter will be referred to the By-Laws Committee and the Executive Committee for consideration and report back next year.

That is the end of Dr. McMillan's report. Next is a report of the Committee to Review the two messages of the President, Dr. Shuford.

DR. SHUFORD: Mr. Speaker and Delegates: The Committee to Review the two Messages of the President felt that any comments by the Committee would be presumptuous, unnecessary, and would more likely detract rather than add to the wise, pertinent and philosophical thoughts of Dr. Baker.

We wish to thank Dr. Baker for his excellent year of office tenure. As so aptly expressed by Dr. John Kernodle, "Dr. Baker certainly has the capacity to stimulate those with whom he is associated into performing tasks far beyond their normal capabilities."

Speaking from my own experience during the year just past, Lenox will work the hell out of you and doesn't mind letting you know exactly what he expects and wants and makes you enjoy doing it. To me this is the mark of the true leader.

The Committee felt that his messages were probably the most thought-provoking and heart-warming ever heard before the Society. We wish him all the luck in the world and complete success in his future activities. We know that he will bring further honors to his own name and to the North Carolina State Medical Society. Thank you! (Applause)

SPEAKER KOONCE: Do I hear a motion that the report of this Committee be ac-

 cepted ?

DR. SAMS: I so move.

(The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.)

SPEAKER KOONCE: Is there any new business to come before this session? If not, do I hear a motion to adjourn?

(Upon motion regularly made and seconded, it was voted to adjourn. The meeting adjourned at three-fifteen o'clock.) The House of Delegates adjourned Sine Die.

GENERAL SESSIONS

THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA ONE HUNDRED FIFTH ANNUAL SESSION

> Asheville, North Carolina General Sessions May 5-6, 1959 FIRST GENERAL SESSION Tuesday, May 5, 1959

The First General Session held in connection with the One Hundred and Fifth Annual Session of The Medical Society of the State of North Carolina convened at nine-ten o'clock in the Assembly Hall of the City Auditorium, Asheville, North Carolina, the meeting being called to order by Dr. John S. Rhodes, Chairman of the Committee on Arrangements.

CHAIRMAN RHODES: It is my particular privilege to present to you at this time the President of the North Carolina Medical

Society, Dr. Lenox Baker.

PRESIDENT BAKER: One of the first functions that we have this morning is to recognize distinguished guests.

(Guests were recognized.)

Our next function is to recognize Dr. Bellows who will make the awards for papers presented last year.

(De. Bellows presented his report.)

PRESIDENT BAKER: This is an innovation at this meeting, probably something which should have been done years before, that is, giving a past president's jewel to each of the living past presidents.

(Dr. Baker then called forward the past presidents who were in the audience and asked in each case to have someone escort him to the platform. In the cast of those who were not present, he requested that someone receive the jewel for him.)

PRESIDENT BAKER: It is our pleasure now to present your former presidents and to ask each one of their sponsors please to

pin their jewel on them.

Someone once said that if you want to judge a man's real worth, find out what he does beyond what he is supposed to do. These men represent people who have done things beyond what they are supposed to do. They are the bulwark of our Society and they represent, I think, the best we have.

Thank you, gentlemen, for what you did in your lives and for what you will do in the future. (Applause)

The list of those who received the Presi-

dent's jewel either in person or by proxy were as follows:

Dr. Donald B. Koonce Dr. James P. Rousseau Dr. Zack D. Owens Dr. Joseph A. Elliott, Sr. Dr. James Street Brewer Dr. Frederic C. Hubbard

Dr. Roscoe D. McMillan Dr. G. Westbrook Murphy Dr. James F. Robertson

Dr. William M. Coppridge Dr. Paul F. Whitaker Dr. F. Webb Griffith

Dr. Hubert B. Haywood Dr. J. Buren Sidbury Dr. Wingate M. Johnson

Dr. Wingate M. Johnson Dr. Charles F. Strosnider Dr. Hubert A. Royster

Dr. Carl V. Reynolds

I next have the honor of presenting a speaker of particular interest to me. I came to this State on Easter weekend in 1929.

I was taken over to the old Bivens Building. A gentleman was sitting there with a pipe in his mouth, wearing thick glasses, and there were papers everywhere. Jimmy Dehart introduced me to Wilbert Davison. He wanted to know if I could get to medical school.

He said, "If he is good enough for you, he is good enough for us. I will take him on at medical school."

Thank you, Dr. Davison, and will you discuss the "Report on the World Medical Association"?

(The paper was presented by Dr. Davison.)

PRESIDENT BAKER: At this time in the program I am going to break in for a very special announcement.

Dr. Edward Schoenheit, will you find Dr. Julian Moore and bring him to the podium, please?

Dr. Schoenheit, it's my pleasure to ask you, acting in behalf of this Society, and I am acting in behalf of the North Carolina Governor's Commission on Behalf of the Handicapped, and it is a special privilege also at this time to say that I come as well as a member of President Eisenhower's Commission to Employ the Handicapped, to ask you to present to Dr. Julian Moore a citation for Meritorious Service for Employment of the Physically Handicapped, presented to him in the name of Governor Luther Hodges and in the name of President Dwight Eisenhower in recognition of what he has contributed to

the welfare of the handicapped, their re-

habilitation and reemployment.

Julian, it is with a great deal of love and appreciation as President of this Society that I make this presentation and thank you for everyone, particularly those you have helped. (Applause)

To present the person who will make the

next address is a special honor.

The Medical Society of North Carolina has attempted in every way possible to cooperate with The American Medical Association in developing awareness on the part of our students, our future members, our future doctors, of what organization medicine is, of what it does.

We are fortunate to have outstanding student bodies from the three universities. We had the pleasure last evening of having dinner with some 70 of them, and this young man. Julian Maynard, from the Bowman-Gray School of Medicine, is chairman of

that AMA Section. I believe it is the first time we have had an organized section. Julian. it is with a great deal of pleasure

that I present you to The Medical Society of North Carolina.

MR. JULIAN MAYNARD: President

MR. JULIAN MAYNARD: President Baker, Members of the House of Delegates. Ladies and Gentlemen:

First, may I take this opportunity to express on behalf of the seniors of the three North Carolina medical schools our sincere appreciation to the North Carolina State Medical Society for making it possible for us to be here with you in Asheville. We are grateful for this chance to hold our first Student Sectional Meeting and to observe and participate in the functions of your Society.

Few State Medical Societies have taken such steps to acquaint the medical student

with their organization.

The fact that today's students will be the future members of the Society scarcely needs to be mentioned, but the idea that informed students are more likely to become active members deserves much consideration. Our hope is that participation in this small way by the members of the Student American Medical Association will lead to our understanding better the functions of the State Society and our forthcoming role in it. It is our hope also that other State Societies will follow your example.

As many of you realize, the National Organization of SAMA was established in 1950 with the assistance of the American Medical Association and it has grown to a membership of over 50,000 with chapters in nearly every medical school in the United States.

Without a doubt, it represents the medical students of the nation. It was through the three SAMA chapters in North Carolina that we were able to cooperate with your committee advisory to SAMA to arrange our participation here.

Briefly, this is the way we set up our Section on Student AMA. A chairman and a secretary were chosen from on of the schools; a first and a second vice-chairman were chosen from the other two schools, the first vice-chairman to be a junior and to assume the chairmanship in the forthcoming year. These four students, with the assistance of Mr. Barnes, outlined the student activities for the convention. Our first function was to visit the House of Delegates yesterday afternoon. Last night we enjoyed the banquet which you so generously gave for us. Following that, we held our formal sectional meeting. At that time, we heard addresses by Dr. Baker and Dr. Monroe Gilmour concerning the purpose and function of the State Society. After their talks, two students from each medical school presented papers scientific in nature — one of which you will shortly hear. Today we plan to visit the scientific exhibits and various sectional meetings and to lunch as guests of the alumni of our respective schools.

I would again like to express our appreciation to you for making this experience possible. I feel that the privilege of attending and participating in this convention has been educational for us all. We thank you.

PRESIDENT BAKER: We will now hear a paper from Steve Mahaky from Duke University, on the subject of "Regional Brain Cancer Chemotherapy."

(The paper was presented.)

PRESIDENT BAKER: I don't thing we will have to worry too much about the next generation.

The next paper we are honored to have is one for which we can thank our Section on General Practice. I refer to the paper of Dr. Jack Weinberg of Chicago who will address us on "Problems of Aging and Concepts in Their Treatment."

l am asking Dr. John Mewborn, former President of the North Carolina Academy of General Practice, and Chairman for The Medical Society on General Practice this

year, to introduce Dr. Weinberg.

DR. JOHN MEWBORN: Mr. President and Fellow-Members of The North Carolina Medical Society: Our speaker this morning was born in Kiev, Russia. He came to the United States at the age of fourteen. He is a graduate of the University of Illinois College of Medicine.

At the present time he is a diplomate of the American Board of Neurology and Psychiatry. He is Clinical Professor of Psychiatry at the University of Illinois Medical School. He is Attendant Psychiatrist at the Michael Reese Hospital, Consultant in Psychiatry, Fellow of The American Psychiatric Association, a lecturer in psychiatry at the University of Chicago, and a member of the National Committee on the Aged for the National Social Welfare Assembly.

With this gray hair of mine, I am beginning to appreciate the problems of age, and I am looking forward with a great deal of interest to hearing Dr. Weinberg's solution to these problems. It is with great pleasure, from the Section on General Medicine, that we bring to you, through the sponsorship of The S. E. Massengill Company, Dr. Jack

Weinberg.

(Dr. Weinberg addressed the session.)

PRESIDENT BAKER: Our next speaker, instead of Dr. Charles F. Williams presenting the next paper which is from the Section of Pediatrics, and the title of which is "A Study of Infant Deaths in North Carolina," will be presented by Dr. Dan P. Boyette, Jr., of Ahoskie, North Carolina.

(The paper was read by Dr. Boyette.) (The Chair was assumed by Secretary John S. Rhodes.)

CHAIRMAN RHODES: The next on the program is an address by Dr. Robert E. Coker, Jr., of the School of Public Health, Chapel Hill. This paper comes from the Section on Public Health and Education and s titled "The Medical Student, Specialization and General Practice."

(The paper was presented by Dr. Coker.) CHAIRMAN RHODES: The next paper s by Dr. Benjamin Hoffmeyer, an address on "Services Available to the Medical Practitioner at the State School for the Deaf at

Morganton.'

This is from the Section on Ophthalmology

and Otolaryngology.

(The paper was presented by Dr. Hoffmeyer, and it was followed by a demonstration given by the teacher and some of her students from the State School for the

Deaf.)

CHAIRMAN RHODES: Before we reach the next item on the program, I would like to recognize a gentleman in the audience, an honorary member of the Society, a North Carolinian, formerly head of the AMA office in Washington and now Vice President of the Joint Blood Council in Washington, Dr. Frank Wilson.

Dr. Wilson, will you stand, please?

(Announcements.)

CHAIRMAN RHODES: It is my pleasure to present to you now our First Vice President and, after tomorrow. President-elect of the North Carolina Medical Society, Dr.

Amos N. Johnson.

DR. JOHNSON: Dr. Rhodes, Friends: The job that I have of presenting this year's President to you is one of the most pleasant jobs that I think I have ever had. I am sorry that I did not know until about 20 or 30 minutes ago that I was going to have the opportunity of doing this because I would love to have prepared a 20-minute introduction telling you all about this man. Actually it would take 20 minutes, and perhaps more, to tell you of the many, many things and the many, many interests and the many qualities that he has of excellence. But you have observed him in running this meeting this year, and many of you have observed him over the years.

We have had many, many things in common, and I have enjoyed knowing this man as much as anyone I have ever known in my life. He is a dynamic personality, he is a hard, tireless worker and he has no lack of confidence in himself, and the important and interesting part of that is that he has the ability to back up this confidence in him-

I could go on and on just talking about Lenox, but he has a paper that is going to be of tremendous interest to us to present now, and it is going to be of more interest as we go along in this changing world. No longer can medicine or medical men stay in their own little shell and assume that the world is going to look after them. If we don't come out of our shell and begin to look after ourselves and mend our own fences, no once else is going to do it for us, and they will close the fence with us on the outside.

I have read this paper you are about to hear, and I want to urge you to listen closely to what he has to say, because I think it is one of the most important things facing medicine now.

The audience arose and applauded.)

(President Lenox D. Baker presented his Annual Address.)

(The audience rose and applauded.)

DR. AMOS JOHNSON: I am sure all of us, when we have analyzed the message that has been brought to us by Lenox today, will get something out of this. If we will follow through on his suggestion to fill out these cards and see that they get into the Home Office in Raleigh, I am sure that we will have pooled information there that will serve us in good stead many, many, many times.

Thank you, Lenox, for having been one of the best Presidents that this Society has ever had. Thank you for the work that you have done, and I am speaking on behalf of every body here and those in medicine in North Carolina who are not here. Thank you for streamlining this meeting. It has run more smoothly this year than any time I have ever seen.

We are all grateful to you, and we wish you many, many happy years in medicine and those associated with The State Medical

Society.

The House of Delegates meets this afternoon at two-thirty in the East Ballroom of the George Vanderbilt Hotel. We will stand adjourned.

(The meeting adjourned at twelve o'clock.)

The President's Dinner
May 5, 1959
The Auditorium
Asheville, N. C.

Tuesday Night Dinner May 5, 1959

The President's Dinner was held in the Assembly Hall of the City Auditorium, Asheville, North Carolina, at seven o'clock.

The meeting was opened by brief comments by the President, Dr. Lenox Baker.

PRESIDENT BAKER: Now I want to introduce to you your next leader. I think we have been fortunate in getting a kind, understanding individual. I am certain he is an entirely different personality than that to which I have tried to make you become accustomed. Now it is my pleasure to recognize a wonderful family, and I want to ask Dr. John Reece to come forward.

And you should meet John's lovely daughter. She is sixteen years of age. I wish tonight that we could sing, "Thank God for Little Girls." Adelaide, come up here, please.

This is a great boy. I have known him a long time. I have watched him. Sweetheart, where are you? Will you stand up, please? I want to thank you from the bottom of my heart.

(At this point Dr. John C. Reese was sworn in as President-Elect, with the follow-

ing oath:)

"I, John C. Reece, solemnly swear that I shall carry out the duties of the Office of President of the Medical Society of the State of North Carolina to the best of my ability. I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people, and to the task of

bringing increasingly improved medical care within the reach of every citizen. I shall uphold the Constitution of the United States and the Constitution and By-Laws of the Medical Society of the State of North Carolina at all times. I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. I do solemnly swear that I will discharge the duties of office to the best of my ability, so help me, God." (Applause) PRESIDENT REECE: Thank you very

much, Lenox. I promise you that I will not

bore you with a long address.

I am thinking now of one of the things they said many years ago about Stephen N. Douglas when he wanted to be President of the United States. That was before he had the debates with Abraham Lincoln. Some of the men who helped to make presidents were having a bull session in Washington one time, and one of them said, "What do you think has happened? Steve Douglas wants to be President."

One of them said, "Why I can't think for the life of me any reason why he wants to be President at 44. He would have to be

good the rest of his life."

I consider myself more fortunate than Steve Douglas as I was elected President of this honorable Medical Society and I have the opportunity of serving you, and the time I really want to be good is the next year when I am serving as your President.

May I express to you my sincere appreciation of the confidence that you have shown in me and the honor you have bestowed upon me. I accept the office with the full realization of the responsibilities that are mine, and I pledge to you, with the help of the other officers and the Executive Council, to carry out a program of organized medicine in North Carolina that will be to the benefit of all doctors and our citizens.

At this time I wish to recognize my Vice President, Dr. Charles M. Norfleet of Winston-Salem and Mrs. Norfleet. (Applause)

There is one other charming lady here representing the Auxiliary of the Medical Society. I refer to Mrs. Robert L. Garrard, the new President of the Auxiliary. (Applause) Robert, you stand up, too, and let them see you. Thank you very much! This is all, and let's enjoy the evening.

DR. DONALD KOONCE: My purpose here at the microphone at the present time is to present the President's medal, which is a very honored position as far as I am concerned, to present the medal to anybody who has done as wonderful a job as Lenox Baker

has.

I think for me to be presumptuous enough tell you about Lenox Baker would be rather idiculous. He is one of the grandest people nat I have ever met. It is with a great deal f pleasure and with God's blessing that I rould like to present to him the President's ewel.

Also, I would like at this time with a great eal of pleasure to present to him this ribon, the Past President's Ribbon, which I

m passing on to him.

DR. BAKER: I told you a moment ago I ras through. I had an interesting experience bout six months ago. Dr. Paul Whitaker, whom we all love, said, "You are going prough a great year. I have gone through similar year. Soon you will be through. Iay I give you one piece of advice? When ou get through accept all the glory you have ad, step aside graciously, realize that the ext generation knows more than you know, ney know their problems better than you o, and please be an elderly adviser available then needed."

I pray to God I can do that, and I thank ou from the bottom of my heart for the reatest honor that I have ever had or can ver have, to be President of the Medical ociety of North Carolina. Goodby!

(The friends of the President formally roceeded into the participation of the Presi-

ent's Ball.)

WEDNESDAY MORNING SESSION May 6, 1959

The Second General Session convened in the Assembly Hall of the City Auditorium to nine o'clock, Dr. Amos N. Johnson, of arland, First Vice President, presiding.

CHAIRMAN JOHNSON: The Second

eneral Session of this Annual Convention ill now come to order. I want to thank a ew of you brave souls who got up so early its morning after having gone to the banuet last night to come over and be with us. am quite sure that you will be rewarded or your effort.

(Some announcements were made by Dr.

hodes.)

CHAÍRMAN JOHNSON: The first peaker on the program this morning is refessor of Clinical Medicine at the Medical ollege of Virginia. He is a man who is eld in high esteem by his fellow-practitioners in internal medicine. He is immediate ast District Governor of the American Colge of Physicians and at present is Regent the American College Physicians.

It is with a lot of pleasure that I introduce you Dr. Charles M. Caravati from Rich-

ond Medical College of Virginia.

(Dr. Caravati presented his paper, entitled "The Management of Peptic Ulcer.")

CHAIRMAN JOHNSON: From the Section on Radiology comes our next paper. It is being given to us by one of our physicians in North Carolina who is in the private practice of medicine and who is doing an excellent job in his field and who is also doing work to qualify him to bring to us a scientific paper. Not only is this man interested in radiology, but he is interested in medicine in North Carolina.

He is currently on our Board of Licensure and it gives me a lot of pleasure to introduce Dr. Thomas G. Thurston from the Section

on Radiology.

(Dr. Thurston presented his paper.)

CHAIRMAN JOHNSON: As another from the Section on Internal Medicine comes our next speaker. He is with the Department of Medicine at the Duke University Medical School, I think as of last week he is the immediate past President of The American Society of Internal Medicine and the North Carolina Society of Internal Medicine, and I am sure that we are all going to be very interested in the topic of his discussion this morning.

I am happy to present to you Dr. Elbert L. Persons from the Department of Medicine at Duke.

(Dr. Persons read his paper on "The Position of the Internist and Other Non-Surgical Specialists in the Pattern of Medical Care".)

CHAIRMAN JOHNSON: Dr. Persons has presented in an excellent manner a very real problem which we have in North Carolina and which exists in other states, as well, all over the United States.

Our next paper, and the last one before the Conjoint Session, is from the Department of Anesthesiology, and the title of the paper is "Emergency Artificial Respiration."

Dr. Safar, who is the Head of the Department of Anesthesiology at Baltimore City Hospital in Baltimore, was to give this paper, but, due to circumstances beyond his control and our control, he was not able to come. Dr. Safar has sent us a man who comes to us from South Carolina by way of Baltimore, and before he got to Baltimore by way of Raleigh, North Carolina, where he interned. He is excellently capable of presenting this paper. He is Dr. Joseph Redding, Assistant Chief in Anesthesiology at the Baltimore City Hospital. He is instructor of anesthesiology at the Johns Hopkins School of Medicine and instructor in anesthesiology at the University of Maryland School of Medicine.

(Dr. Joseph Redding presented the paper. entitled "Respiratory Resuscitation.")

CHAIRMAN JOHNSON: Thank you, Dr. Redding, for presenting to us this very interesting paper on resuscitation.

The time has come, as is required by law, that we recess this Second General Session and that we have the Conjoint Session of

the North Carolina State Board of Health. (The General Session recessed at ten twenty o'clock.)

CONJOINT SESSION WEDNESDAY, MAY 6, 1959

The Conjoint Session of the North Carolina State Board of Health convened at ten twenty o'clock a.m., Dr. Charles R. Bugg, Raleigh, President of the North Carolina State Board of Health, presiding.

DR. AMOS JOHNSON: Many of you who have been coming to these sessions for years as I have, I believe will have a feeling of profound sadness, as I know I do, that Grady Dixon is not here today to preside at this

Conjoint Session.

As you know, Grady was President of the State Board of Health for years and years and did an excellent job. Grady always looked forward to being at the meeting and to presiding. Grady presided one year ago at this Conjoint Session, and at the end of the meeting at noon that day got in his car and started home. He became acutely ill as he was getting down to the foothills and died within probably four or five hours of the time that he presided here. We will all miss Grady Dixon in the affairs of medicine and as an ingratiating personality.

We have, however, as his successor, Dr. Charles R. Bugg, who is President of the North Carolina Board of Health, and he will

preside at this meeting.

CHAIRMAN BUGG: Thank you very

much, Dr. Johnson.

The first thing I would say is to concur with Dr. Johnson in the name of the Board of Health in our great loss in that one year ago today, Dr. Grady Dixon died. He will never be replaced.

The Board of Health agrees with Dr. Johnson and with the resolution adopted in the House of Delegates which specifically applies to our friend, Dr. Grady Dixon.

I will now ask Dr. Roy Norton, the State Health Officer, to hand to Dr. Johnson the official activities of the State Board of Health for the year.

(Report was handed to Dr. Johnson.)

DR. NORTON: President Bugg, I have the detailed report, and, as has been customary for several years, a short discussion of some of the things that are so important in working together from the standpoint of the State Board of Health and the local boards' local staffs and with the other members of the Medical Society, will be given.

Dr. Bugg, our President, has consented to give that report, and I will turn over our detailed report of activities for the year. (Dr. Bugg presented a briefed report.)

CHAIRMAN BUGG: There are some other members in the State Board of Health present. I will ask them to stand up as I scall their names. They are Dr. John R. Bensder, Mr. H. C. Lutz, Pharmacist, Dr. Lenox Baker, Dr. Roger W. Morrison, Dr. Earl W. Brian.

I believe that completes this session and the Conjoint Session is now adjourned.

(The Session adjourned at ten-fifty o'clock.)

SECOND GENERAL SESSION (Continued) WEDNESDAY, MAY 6, 1959

The Second General Session reconvened at ten-fifty o'clock, Dr. Amos N. Johnson presiding.

CHAIRMAN JOHNSON: The Second

General Session will convene again.

As many of you know, there has been considerable thought taken and action instigated in medicine to make some changes in some of the insurance plans and the structure of some of the plans that have been rather farreaching.

In this work, the State of Iowa has pioneered, and in order that most of us in North Carolina shall be able to get the benefit of the experiences which they had in Iowa, we have arranged from the Section on Pathology to have a paper given on this

subject,

Dr. Coleman, who is a pathologist in Des Moines, was scheduled to give this paper, but he has been unavoidably detained and could not get here. However, I have reason to believe that we may be fortunate to have the eminent legal counsel for the Medical Society of the State of Iowa to come and give this paper in his stead.

Mr. Robert Throckmorton from Des Moines

is here and will give us his paper.

Mr. Throckmorton went through the legal aspect of all of this with the State of Iowa, and he is more than passably interested in medicine. His father is a doctor, and he has a brother who also is a doctor there. I am sure we are fortunate to have Mr. Throckmorton with us. (Applause)

(Mr. Throckmorton presented his ad-

dress.)

CHAIRMAN JOHNSON: I want to thank Mr. Throckmorton for what I think is one of the finest presentations of a problem of this kind that I have ever heard. He has given us a lot of ideas, and he is going to be available today for members of your Negotiations Committee and others interested in this problem to have further conferences with him. I am sure that his trip here from Iowa is going to bring big dividends.

I would like now to recognize Dr. Jacob Shuford who will present one of our outstanding doctors to you in a moment.

DR. SHUFORD: It is my pleasure to present Dr. John Reece, your new President.

(The audience rose and applauded.) (Dr. John C. Reece presented his prepared address.)

(Applause)

CHAIRMAN JOHNSON: On behalf of all of us here and on behalf of all of us in medicine in North Carolina, I want to thank President Reece for his fine paper and the fine thoughts which he has brought out in the paper. I am sure that he will make an outstanding President and that under his leadership in the next year we will make much progress in North Carolina.

(There were announcements

Rhodes.)

CHAIRMAN JOHNSON: We have one matter more before we close this Second Session, and that involves the election of two members of the Editorial Board of the North Carolina Medical Journal.

The floor is now open. Do I hear nomina-

tions?

DR. SAMS: Mr. Chairman, I am sure that you and I and every other person who listened to the report of our Financial Secretary are happy to know that for once we made one whole year come out in the black.

That was due to the business management of our editorial board and our business manager of the staff. There are two to be elected to the Board, and it is my privilege and pleasure to nominate Dr. John B. Graham from Chapel Hill and Dr. William Nicholson from Durham as succeeding members of the North Carolina Medical Journal Editorial Board.

CHAIRMAN JOHNSON: You have heard the conjoint nominations by Dr. Sams, and I suppose it will be all right to act on them as a twosome unless I hear further nomina-

tions from the floor.

DR. BEN ROYAL: I move that nominations be closed and that the Secretary be nstructed to cast the unanimous vote of the Society for these two nominees.

(The motion was seconded. Discussion was

called for. There being no discussion, the motion was put to a vote and carried, and the two nominated were declared elected.)

CHAIRMAN JOHNSON: We are running approximately fifteen minutes ahead of time. We will take a fifteen-minute recess and then we will come back and have the Third Session.

We will convene again at twelve o'clock sharp.

(The Session adjourned at eleven fortyfive o'clock.)

> THIRD GENERAL SESSION WEDNESDAY, MAY 6, 1959

The Session convened at twelve-five o'clock, Dr. John C. Reece, President, of Morganton, North Carolina, presiding. PRESIDENT REECE:

The Third General Session of the North Carolina Medical

Society is now convened.

This represents some changes in our program as we have followed it in past years. We have brought to this hour the five o'clock session that used to be on the last afternoon.

At this time, the Society is honored with the presence of many of our physicians who are to receive their 50-year pins. We welcome

At this time, I recognize our retiring President, Dr. Lenox Baker, to make the formal presentation.

DR. BAKER: John was very kind to say "retiring." After last night, I feel as if I have retired.

This is my first act as a retired or former

President of the Society.

This is an official act. This is official recognition of services rendered by some of our members to the people of North Carolina for 50 years.

I am honored in having the privilege of calling these people and calling their friends with them and, in some instances, calling the person who probably made them successful in their endeavors. I have often thought that we gave the pin to the wrong people, anyway.

(Dr. Baker then called the following names as persons who were to be received into

the Fifty-Year Club:

Christopher S. Barker, M.D. New Bern (Craven Co.) Benjamin F. Royal, M.D. Morehead City (Carteret) Reuben Gray Tuttle, M.D. Winston-Salem (Forsyth) Thomas Dalton Crouch Stony Point (Iredell-Alexander) Otho B. Ross, Sr., M.D.

Charlotte (Mecklenburg) William A. Johnson, M.D. Greensboro (Guilford) Glenn Choate. M.D. Salisbury (Rowan-Davis) Kinchen Carl Moore, M.D. Laurinburg (Scotland) Lucius Victor Dunlap, M.D. Albemarle (Stanly) Hubert Benbury Haywood, M.D. Raleigh (Wake) Neale Summers Stirewalt, M.D. High Point (Guilford) Edmund Simpson Boice, M.D. Rocky Mount (Edgecombe-Nash) Sylvester Douglas Craig, M.D. Winston-Salem (Forsyth) Charles R. Russell, M.D. Granite Falls (Caldwell) Byrd Charles Willis, M.D. Orange, Virginia (Edgecombe-Nash) Frederick B. Spencer, M.D. Salisbury (Rowan-Davis)

Your Medical Society hopes that you people wear these pins in health and for a long time to come; they are given to you with all

the love of the Society.

While the pins are being pinned on, there is a lady here to whom I should like to introduce you. I had the pleasure of introducing her last night, but some of you gentlemen did not attend the meeting. We have had our meeting honored by one of the finest and greatest First Ladies this State has ever known. She is Mrs. Melvin Broughton. She is here out of respect and love for Hubert Haywood.

Thank you, Mrs. Broughton.

PRESIDENT REECE: While these honored gentlemen are going over to have their pictures made, there are a few items of business, reports from the House of Delegates that should be submitted at this time.

First under consideration is the report of the House of Delegates. This represents the report of the Nominating Committee that was adopted by the House of Delegats.

The following officers were nominated and elected by the House of Delegates at the

1959 meeting in Asheville:

President Elect: Dr. Amos N. Johnson First Vice President: Dr. Charles Norfleet Second Vice President: Dr. William Walton Kitchin Speaker of the House of Delegates: Dr. Donald B. Koonce

Vice Speaker of the House of Delegates: Dr. Edward M. Schoenheit

Councilor for the Second Medical District: Dr. Lynwood Earl Williams

Vice Councilor for the Second Medical District: Dr. Ernest Waddill Larkin

Councilor for the Fourth Medical District: Dr. Edgar Beddingfield

Vice Councilor for the Fourth Medical District: Dr. Donnie Hugh Jones

Member of the State Board of Health for the 3-year term: Dr. Earl W. Brian The convention city for the 1960 meeting

is Raleigh. North Carolina.

That completes the report for the House

of Delegates.

Is there any unfinished business to come before this Third General Session? If there is no unfinished business, is there any new business? There is no new business, apparently.

The following officers, if they are in the audience, will please come forward for in-

stallation:

President Elect. Dr. Amos N. Johnson First Vice President, Dr. Charles Miller Norfleet

Second Vice President, Dr. Walton Kitchin Speaker of the House of Delegates, Dr. Donald B. Koonce

Vice Speaker of the House, Dr. Edward M. Schoenheit

I hereby install you as our present officers.

I wish to express to this Session and to the Nominating Committee and to the House of Delegates my sincere appreciation for the fine slate of officers, these capable men that you have given to us to work with this year. With their help we hope to carry out for you an official program for the Medical Society of the State of North Carolina. We are your servants and the servants of organized medicine.

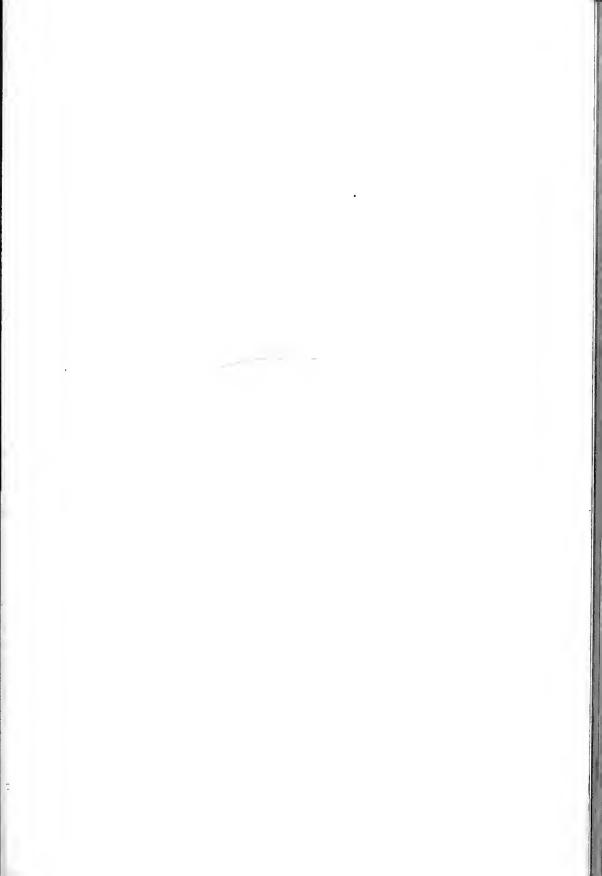
The purpose of medicine is to render medical care to all the citizens of this State.

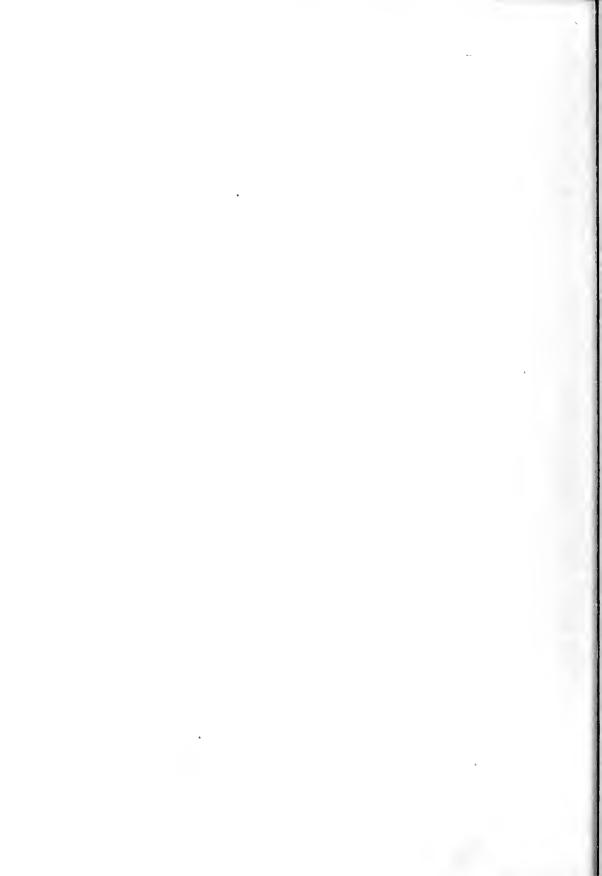
Thank you very much for the opportunity, for the privilege and the honor of serving as your President in the coming year. I hope to be of service to all of you.

We now declare this Session adjourned

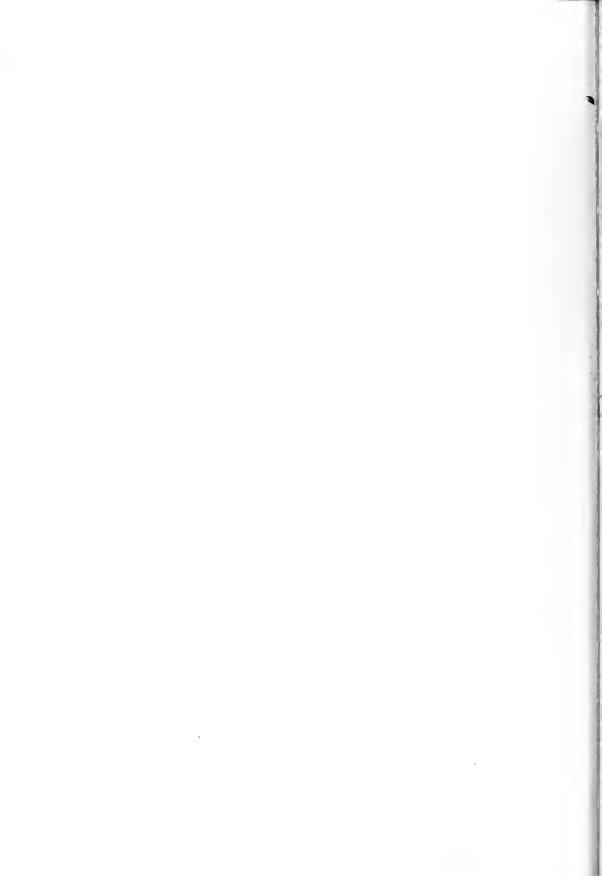
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(The meeting adjourned at 12:20 o'clock.)









NORTH CAROLINA

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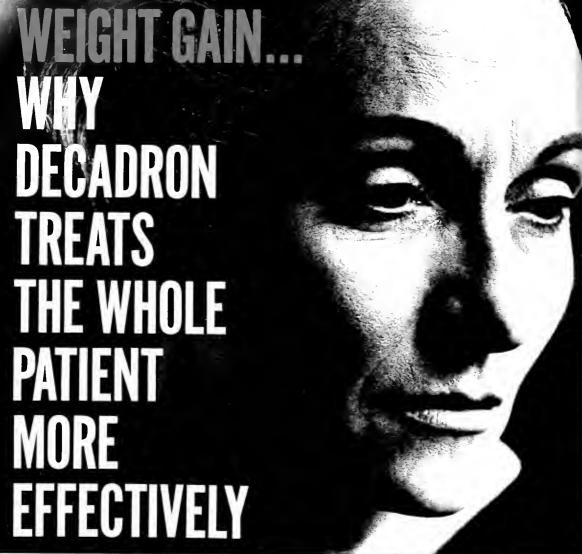
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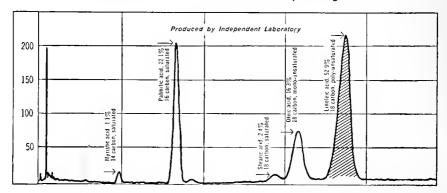
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A significant statement about serum cholesterol and dietary fats

lowered by the judicious substitution of one type of dietary fat for another. However, it is relevant to inquire whether a patient can be assured that such a radical change in his dietary habits will prevent coronary occlusion or a cerebral vascular accident. This question must unfortunately be answered in the negative, for it has not been proved that lowering the level of serum cholesterol will prevent either the occurrence or the end-results of atherosclerosis. At the present time, clear proof of this proposition still seems many years away. Nevertheless, there are many reasons for believing that there is some connection between cholesterol metabolism and atherosclerosis, and, while waiting for elucidation of this relationship by laboratory workers, it seems justifiable to apply certain dietary procedures that are theoretically harmless and possibly beneficial.

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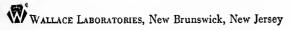
I. Kestler, O.: In The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. 2. Berger, F. M.; Kletzkin, M.; Ludwig, B. J.; Margolin, S., and Powell, L. S.; J. Pharm. Exp. Ther. 127:66 (Sept.) 1959. 3. Spears, C. E. and Phelps, W. M.: Arch. Pediat. 76:287 (July) 1959. 4. Phelps, W. M.: Arch. Pediat. 76:243 (June) 1959. 5. Friedman, A. P.; Frankel, K., and Fransway, R. L.: Papers presented at Scientific Meeting, New York State Society of Industrial Medicine, Inc., New York, Sept. 30, 1959. 6. Kuge, T.: Unpuhlished reports. 7. Ostrowski, J. P.: Orthopedics 2:7 (Jan.) 1960.

Literature and samples on request

Also available on request: The Pharmacology and Clinical Usefulness of Carisoprodol, Wayne State University Press, Detroit, 1959. (185 pages)



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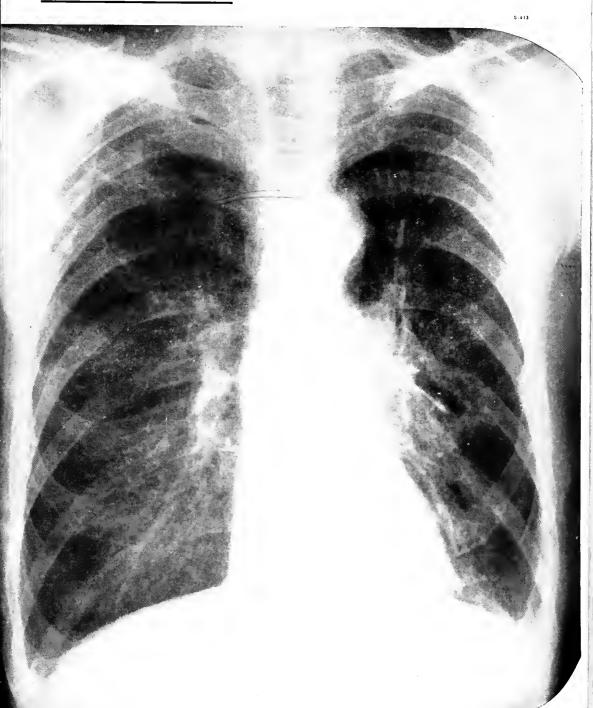
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2. Smith J. G., Jr.; Zawisza, R. J., and Blank, H.: A.M. A. 4rgh. Dermat. 78:643 (Nov.) 1938.





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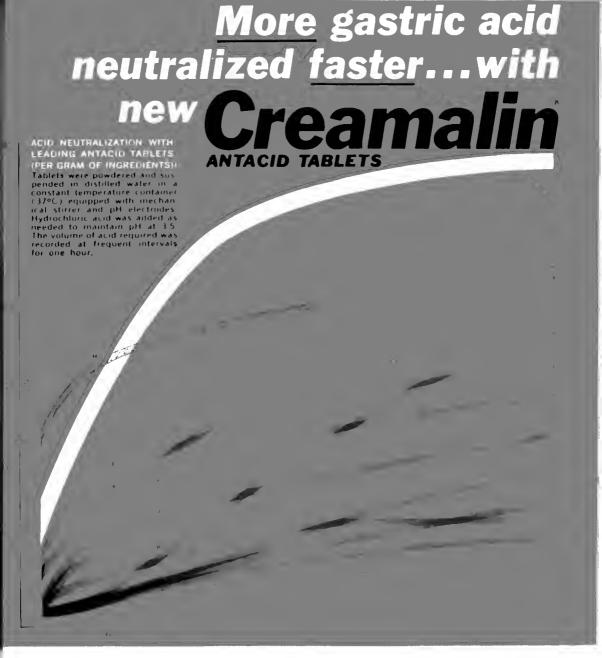
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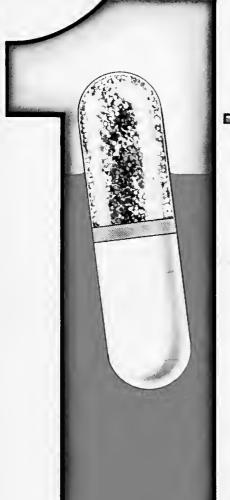
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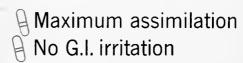
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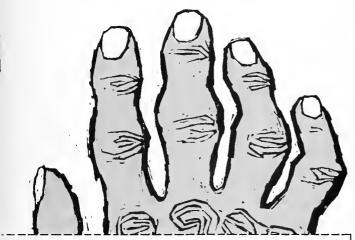
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References
1 Bagnall, A W. Canad M. A. J. 77 182-194,1957.
2. Goodman, L. S., and Gilman, A.
The Pharmacol. Basis of Therapy, 1955, p. 299
3 Smith, P. K., et al.: J. Pharmacol. & Exper
Therap, 87:237-255, 1946.
4 Wiggers, C. J.: Physiol in Health & Disease,
1955, pp. 918, 1011.

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. Atarax appeared to reduce anxiety and restlessness, improve sleep pat-terns and make the child more amenable to the development of new pat-terns of behavior...." Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958.

"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic condi-tions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. 7:61 (Jan.) 1959.

"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medica-ment." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.

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Bayart, J.: Acta paediat. belg. 10:164, 1956. Ayd, F. J., Jr.: California Med. 87:75 (Aug.) 195:16arnia L. A., and Andelman, M. B.: Illinois M. J. 112:171 (Oct.) 1957.

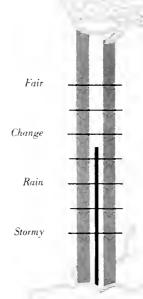
Settel, E.: Am. Pract. & Olgest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Geri-atrics 11:312 (July) 1956.

Elsenberg, 8. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Oec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. 50:1282 (Oct.) 1957.

Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684' (May 15) 1958. Farah, L.: Inter-nat. Rec. Med. 169:379 (June) 1956.

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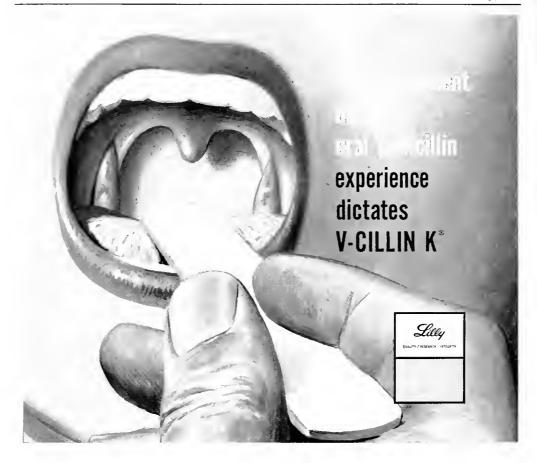
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1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

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VOLUME 21

MAY, 1960

No. 5

The Surgical Treatment of Cerebral Ischemia Caused by Extracranial Vascular Disease

(With Special Reference to Occlusive Disease Of the Internal Carotid Artery)

FREDERICK H. TAYLOR, M.D.
GEORGE C. BLANCHARD, M.D.
WILLIAM R. PITTS, M.D.
TERRY T. REES, M. D.
FRANCIS ROBICSEK, M.D.
and
PAUL W. SANGER, M.D.
CHARLOTTE

A significant percentage of so-called strokes and other clinical manifestations of cerebral ischemia should be considered amenable to surgical correction. Although this fact has been well demonstrated in a few centers, the medical profession as a whole has been slow to accept it. De-Bakey⁽¹⁾, in a study of 174 patients with cerebral ischemia, found that 42 per cent of these patients had extracranial arterial occlusion.

As early as 1875 Broadbent⁽²⁾ wrote of occlusion of the aortic arch vessels. Chiari⁽³⁾, in 1905, described the clinical picture produced by internal carotid occlusion. Hunt⁽⁴⁾, in 1914, pointed out the relationship between cerebral ischemia and carotid artery occlusion. He urged the routine examination of the carotid pulses in all vascular problems involving the central nervous system. Despite these excellent early reports very little was done about the problem until six years ago.

Pathology

Most occlusions of arteries supplying blood to the brain result from atheromatous plaques. Panarteritis has been described in "pulseless disease," or Takayasu's disease, an unusual occlusive disease of the aortic arch vessels described by a Japanese opthalmologist(5). The common sites of occlusion of the extracranial cerebral vessels are shown in figure 1. The internal carotid artery at the bifurcation of the common carotid artery is the most common site of obstruction (6), and most of the comments of this paper will be directed toward this problem. Plagues which produce partial or complete occlusions may also be found in the common carotid, in the syphon area of the internal carotid, in the aortic arch at the origin of the large cerebral vessels, and in the vertebral arteries⁽⁷⁾ (fig. 1.).

The left internal carotid artery is involved by occlusive disease more often than the right⁽⁸⁾. Lyons⁽⁶⁾ has shown that men are four times more frequently affiicted than women.

Fisher^(8b,9), who routinely examines the carotid arteries at autopsy, has shown that severe occlusive disease of the carotid arteries may be accompanied by near-normal intracranial vessels.

Clinical Picture

The clinical picture of carotid artery occlusion depends on the extent of the occlusion and on the amount of collateral circulation furnished by the ipsilateral ophthal-

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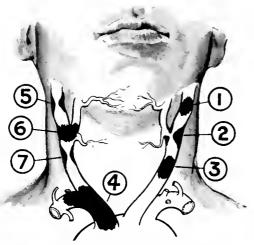


Fig. 1. The most frequent sites of occlusive disease involving the carotid systems.

mic and vertebral arteries and the contralateral cerebral vessels. Symptoms may be absent in the face of partial or complete occlusion of an internal carotid artery, or symptoms may be massive and sudden, giving the classic picture of "stroke." When there is partial occlusion of an internal carotid artery, symptoms may be transient and fleeting. Transient hemiparesis is common. Promonitory signs of hemiparesthesias, unilateral blindness, dizziness, or aphasia may be noted. During periods of hypotension, such as occur with cardiac arrhythmias, myocardial infarction, blood loss, or during surgery, these transient findings may appear. Crevasse(10) believes that hypotensive drugs should be avoided in patients with cerebral vascular insufficiency. Unilateral headache is fairly common in occlusive carotid disease. Fleeting neurologic symptoms from carotid disease are frequently passed off as being due to cerebral "vasospasm." Spontaneous hemiplegia in children and young adults should make one suspicious of carotid disease, as this has been noted in children as young as 1 year of age(11). Visual disturbances are sometimes noted when the head is turned. Head noises synchronous with heart beat have been reported(12). Homonymous hemianopsia occurs sometimes. Facial ischemia as noted by facial pain or atrophy(5a), or even sloughing of the facial skin, has been noted with a common carotid occlusion. A partial or complete Horn-

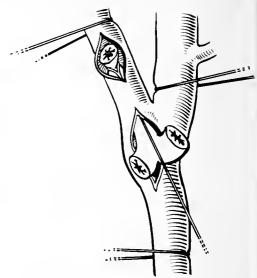


Fig. 2. Schematic drawing showing endarterectomy of carotid bifurcation.

er's syndrome⁽¹³⁾ is fairly common. Diplopia and dysphagia have been reported. A syndrome called "reverse coarctation" has been described^(5a) when the vessels arising from the aortic arch have been occluded. Prominent collateral vessels of the chest wall with rib notching have been noted in this syndrome.

Dementia is common when both carotid arteries show occlusive disease. Severe bilateral neurologic changes might suggest occlusion of the basilar artery, and this may be secondary to occlusive disease in the vertebral arteries.

Other findings to suggest occlusive disease of the carotids are not always reliable. Weakness of one carotid pulse can sometimes be better determined by palpation of the lateral pharyngeal walls with a wet glove. The electroencephalogram is not diagnostic, although Meyer⁽¹⁴⁾ describes some differences in electroencephalographic findings of carotid versus basilar artery occlusion.

Ophthalmodynamometry, a technique for measuring the blood pressure in the retinal vessels, has been termed useful in detecting occlusive carotid disease⁽¹⁶⁾.

A thrill or bruit over a carotid artery is sometimes detected in partial occlusive dis-



Fig. 3. Case No. 4. A. Site of thrombus removed by endarterectomy. B. Autopsy findings one year later when patient died of unrelated causes. The site of previous operation is patent and covered with smooth endothelium.

ease. A systolic bruit over the contralateral eye might indicate an increased collateral blood flow.

Any of the above findings may be present singly or in combination in occlusive carotid disease. However, the "typical picture" of monocular blindness, unilateral headache, and miosis in conjunction with contralateral hemiplegia is unusual.

The clinical findings may strongly suggest occlusion of one or more extracranial cerebral vessels. The suspected vessel should always be visualized by arteriography⁽¹⁵⁾. The carotid system is usually easily visualized by percutaneous needle injection of radio-opaque material into the common carotid artery (8b). When necessary, this can be done with open operation under local or general anesthesia. The aortic arch vessels are well visualized by retrograde aortography. Even the vertebral arteries can be visualized by a technique described by Crawford⁽⁷⁾. DeBakey⁽¹⁶⁾ recommends bilateral carotid angiograms, as unsuspected occlusive disease may be found in the contralateral artery.

Post-stenotic dilatation is occasionally seen in partial occlusive disease.



Treatment

A definitive treatment for occlusive disease of the carotid arteries has been developed in the past few years.

In the past, arterectomy^(8a), cervical sympathectomy^(8b), and denervation of the carotid sinus have been tried and abandoned. Anticoagulant therapy⁽¹⁷⁾ has been tried with equivocal results.

In 1953 Strully⁽¹⁸⁾ made the first attempt to open an obstructed carotid artery by endarterectomy. Unfortunately, the procedure was unsuccessful and the carotid was ligated. In 1954 Eastcott⁽¹⁹⁾ reported the first successful correction of carotid occlusion by local resection of a thrombosed segment with anastomosis of the internal carotid to the common carotid. The patient recovered completely from hemiplegia, Coo-

Table 1

Experience With Ten Cases Related to Cerebral Ischemia

Cas No		e Se	x Duration toms	n of Symp- and Signs	Laboratory Findings	Arteriographic Findings	Surgery	Result
1.	15	М	4 days	Sudden loss of conscious- ness right Babinski, right hyper- reflexia	Abnormal EEG over entire left hemisphere	Complete left internal caro- tid obstruc- tion beyond bifurcation	General anesthesia with hypothermia; endarterectomy with good back flow	Good
2	54	M	1 year	Transient dizziness, blurred vision, nn-steady gait. One convulsion, hemiparesis, unilateral blindness	L.P. normal	Complete right internal caro- tid obstruc- tion at bif: cation	General anesthesia; endarterectomy but no back flow	No improve- ment
3.	50	М	1 day	Transient blurring of vision. Left Hemipare- sis, slurring of speech. Di- plopia. Left Babinski.	Normal	Complete oc- clusion, right internal caro- tid at bifur- catic:	Endarterectomy with good back flow	Complete recovery
L	56	M	3 months	Weakness, left arm; increased tendon re- flexes, left arm; dimin- ished caro- tid pulse, right	Normal	Partial occlusion, right internal carotid at bifurcation (fig. 4)	Local anesthesia; Endarterectomy with good back flov	Complete recoverv
5.	59	М	3 years	"Stroke" 3 years ago; mental con- fusion; in- ability to concentrate; congestive heart failure	EEG-diffuse cerebral changes; Car- diac enlarge- ment	Complete occlusion R.I.C.A. at bi- furcation. Par- tial-occlusion left l.C.A. at bifurcation	Right carotid endarterectomy but with no back flow; Left carotid endarterectomy, but no oack flow	Died 2 weeks after 2nd operation. Antopsy showed com- plete occlu- sion both I.C.A inside skull; narrowing of vertebral and basilar arteries

ley⁽¹²⁾, in 1956, reported success with endarterectomy. Others⁽²⁰⁾ followed with local resections and anastomoses, replacement by vein grafts, and endarterectomy. Subsequently the classic work of DeBakey^(1,16) and his group put surgical management on a firm footing. Rob^(5b) and Lyons⁽⁶⁾ also contributed to the surgical management of this problem.

Surgical treatment at present is divided between endarterectomy (fig. 2) and bypass graft. Both procedures have their place, Short segmental occlusion is often corrected by endarterectomy, whereas the longer segmental occlusions usually require by-pass grafts. When the carotid arteries are cross-clamped for correction of partial

occlusion, brain damage is prevented by the adjunct of hypothermia (30-32° C.) (5b) or with the aid of a temporary plastic by-pass tube (8a). The cerebral collateral blood flow should be tested preoperatively by carotid compression (5a). When a carotid artery is completely occluded, neither hypothermia nor temporary by-pass is of benefit during surgery.

Review of Cases

Our experiences with 10 cases related to the problem of cerebral ischemia are summarized in table 1. Six of the 10 were in their sixth decade of life. One was a boy of 15. All but one were males. The duration of symptoms varied from 12 hours to one year. Contrary to the various experiences

Table	1	(Continued)
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					Table 1	(Continued)		
6.	30	М	12 hours	Thrombosis, left C.C.A. following temporary occlusion of both C.C.A. for clipping of right I.C.A. in cranium.		Not done	Left C.C.A. explored and fractured intima encountered. Re- peated endarterec- tomies with recurrent clot formation.	Died 1 hour postopera- tively. Autop- sy showed complete occlu- sion left I.C.A. operative oc- clusion intra- cranial por- tion of right I.C.A.
7.	53	F	3 days	Left hemiplegia following temporary occlusion of right C.C.A. for intracranial aneurysm.		Not done.	Removal of clot right C.C.A.	Temporary im- provement for few hours; re- turn of com- plete left hemiplegia
8.	52	M	2 weeks	Right hemi- paresis and hemipares- thesia. Transient aphasia. Right hy- perreflexia and Babin- ski.	EEG normal	Complete occlusion left I.C.A. at bifurcation. (fig. 5)	Endarterectomy, but no back flow	No improve- ment
9.	40	M	1 day	Stab wound, left neck with A.V. fistula. Aphasia. Right lower facial weakness. Thrill and machinery murmur beneath angle of left mandible.		Not done.	Hypothermia. A.V. fistula between left C.C.A. at bifurcation and int. jugular vein repaired.	Complete recovery
10.	42	М	1 year	Transient blindness and fainting episodes.	Normal oph- thalmo-dyna- mometry.	Segmental occlusion left subclavian at aortic arch.	Endarterectomy left subclavian artery at aortic origin with good back flow. (fig. 6)	Recovery with palpable ra- dial pulse

reported by others, the right carotid system was involved as often as the left in our series. Arteriograms were done in all cases except for the 2 patients with postoperative thrombosis and in the 1 case of arteriovenous fistula. In no case was an arterial graft used. Endarterectomy was done in all cases with the exception of case 9 (repair of an arteriovenous fistula) General anesthesia was used for the most part and 2 patients in addition were put under hypothermia.

Results

Five cases showed good results or complete recovery up to two years postoperatively. One of these improved patients (case 4) died of an unrelated cause one

year after endarterectomy. Autopsy showed a patent carotid bifurcation with smooth endothelium at the site of endarterectomy (fig. 3). Three patients were not improved, and 2 died. In these unfavorable cases no backflow of blood was obtained after endarterectomy was done. This fact, of course, confirms the oft-stated truism that an artery must be patent distally before any local correction of obstruction will be successful.

Case 10 warrants some discussion in that this man had cerebral symptoms of transient blindness and fainting. Retrograde left brachial arteriogram showed almost complete segmental occlusion of left subclavian artery at the aortic origin (fig. 6). The innominate artery and left common



Fig. 4. Case No. 4. Right carotid arteriogram showing partial occlusion of internal carotid artery at the bifurcation.

carotid artery were found to be patent by palpation of the neck vessels and by visualization using intravenous aortography. Although the left vertebral artery showed filling, the proximal obstruction of the left subclavian artery confirms the current thought that a good pulse pressure, as well as blood flow and mean pressure is necessary for an organ to have normal blood supply.

Summary

The general subject of cerebral ischemia due to extracranial vascular disease is discussed. Many authors have shown that cerebral ischemia can often be improved by direct surgical treatment of the extracranial vessels which supply blood to the brain.

Our experiences with 10 cases is described.

References

- DeBakey, Morris, E., Crawford, E. S., Cooley, D. A., and G. C., Jr.: Surgical Considerations of Occlusive Disease Innominate, Carotid, Subclavian, and Vertebral Arteries. Ann. Surg. 149:690-710 (May) 1959.
- Broadbent, W. H.: Absence of Pulsation in Both Radial Arteries, the Vessels Being Full of Blood, Clin. Soc. 8:165, 1875.
- Chiari, H.: Ueber das Verhalten des Teilungswinkels der Carotis communis bei der Endarteritis Chronica deformans, Verh. Dtsch. Path. Ges. 9:326, 1905.



Fig. 5. Case No. 8. Left carotid arteriogram showing complete occlusion of internal carotid artery at bifurcation.



Fig. 6. Case No. 10. Retrograde left subclavian arteriogram showing almost complete occlusion of subclavian artery at its aortic origin. Retrograde filling of vertebral artery is noted. (See text).

- Hunt, J. R.: The Role of the Carotid Arteries in the Causation of Vascular Lesions of the Brain, with Remarks on Certain Special Features of the Symptomatology. Am. J. Med. Sc. 147:704-713 (May) 1914.
- (a) Gurdjian, E. S., and Webster, I. E.: Thrombo-Endarterectomy of the Carotid Bifurcation and the Internal Carotid Artery, Surg., Gynec. and Obst. 105:421-526 (April) 1958. (b) Rob, C., and Wheeler, E. B.: Thrombosis of Internal Carotid Artery Treated by Arterial Surgery, Brit. Med. J. 2:264-266 (Aug. 3) 1957. (c) Shimizu, K., and Sano, K.: Pulseless Disease, J. Neuropath & Clin. Neurol. 1:37-47 (Jan.) 1951. (Abst. J.A.M.A. 145:1095, 1951).
- Lyons, C., and Galbraith, G.: Surgical Treatment of Athersclerotic Occlusion of Internal Carotid Artery. Ann. Surg., 146:487, 1957.
- (a) Crawford, E. S., DeBakey, M. E., and Fields, W. S.: Roentgenographic Diagnosis and Surgical Treatment of Basilar Artery Insufficiency, J.A.M.A. 168:509-514 (Oct. 4) 1958. (b) Hutchinson, E. C., and Yates, P. O.: Cervical Portion of Vertebral Artery: Clinico-pathological Study, Brain 79:319-331 (June) 1956.
- (a) Chao, W. H., Kwan, S. T., Lyman, R. S., Loucks, H. H.: Treatment of Carotid Occlusion by Arterectomy. Arch. Surg. 37:100, 1938.
 (b) Fisher, M.: Occlusion of the Carotid Arteries; Further Experiences, A.M.A. Arch Neurol. & Psychiat. 72:187-204 (Aug.) 1954.

 Fisher, M.: Occlusion of the Internal Carotid Artery, A.M.A. Arch. Neurol. & Psychiat. 65:346-377 (March) 1951.

- Crevasse, L. E., Logue, R. B., and Hurst, J. W.: Syndrome of Carotid Artery Insufficiency; Early Clinical Recognition and Therapy, Circulation 18:924-934 (Nov.) 1968.
- (a) Cabieses, F., and Saldies, C.: Thrombosis of the Internal Carotid in a Child, Neurology 6:677-678 (Sept.) 1956.
 (b) Teng, P., and Goldberg, E. D.: Thrombosis

- of Internal Carotid Artery in a Five Year-Old Child. A.M.A. J. Dis. Child. 99:228-230 (Feb.) 1960.
- Cooley, D. A., Al-Naaman, Y. D., and Carton, C. A.: Surgical Treatment of Arteriosclerotic Occlusion of Common Carotid Artery, J. Neurosurg. 13:500-586 (Sept.) 1956.
- Lin, P. M., H. Javid and E. J. Doyle: Partial Internal Carotid Artery Occlusion Treated by Primary Resection and Vein Graft; Report of a Case. J. Neurosurg. 13:650-655 (Nov.) 1956.
- Meyer, J. S., H. Leiderman, H., and Denny-Brown, D.: Electroencephalographic Study of Insufficiency of the Basilar and Carotid Arteries in Man, Neurology, 6:455-477 (July) 1956.
- Johnson, H. C., and Walker, A. E.: Angiographic Diagnosis of Spontaneous Thrombosis of Internal and Common Carotid Arteries, J. Neurosurg. 8:631-659 (Nov.) 1961.
- DeBakey, M. E., Morris, G. C., Jordan, G. L., Jr., and Cooley, D. A.: Segmental Thrombo-obliterative Diseasa of Branches of Aortic Arch, J.A.M.A. 166:998-1003 (March 1) 1958.
- Kalmansohn, R. B., and Kalmansohn, R. W.; Thrombotic Obliteration of the Branches of the Aortic Arch. Circulation 15:237-244 (Feb.) 1957.
- Strully, K. J., and others: Thromboendartectomy for Thrombosis of Internal Carotid Artery, J. Neurosurg. 10:474, 1953.
- Eastcott, H. H. G., Pickering. G. W., and Rob. C. G.: Reconstruction of Internal Carotid Artery in Patient with Intermittent Attacks of Hemiplegia, Lancet 2:994-996 (Nov.) 1954.
- (a) Bahnson, H. T., Spencer, F. C., and Quattlebaum, J. K., Jr.: Surgical Treatment of Occlusive Disease of the Carotid Artery, Ann. Surg. 149:711-720 (May) 1969.
 (b) Edwards, C., Rob, C. G.: Relief of Neurological Symptoms and Signs by Reconstruction of a Stenosed Internal Carotid Artery. Brit. Med. J. 2:1265, 1956.

Resuscitation in Electrical Injuries

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Electrical injuries originate from two sources: lightning and line current. They may be brought to the physician's attention in one of two stages: immediately after the injury, as a result of the shock itself, or later, because of symptoms resulting from injuries related to the shock.

Classification

Five categories of injuries are associated with electrical shock: (1) burns, (2) muscular contraction, (3) secondary injuries, (4) central nervous system effects, and (5) cardiac effects.

Burns: The burns associated with electrical injuries are caused by arcing, which produces a thermal burn at the point of contact with the arc; or electrical coagula-

tion, a result of heat from the resistance of the tissue.

The treatment of electrical burns does not differ from that of other thermal burns, and since this discussion is concentrated on resuscitation, it will not be discussed here.

Muscular contraction: The injuries from muscular contraction are caused by the contractile force of the muscle stimulated by the electrical current. The injuries consist of ruptured muscles or tendons and of fractured bones secondary to the abnormal muscular contraction. Because these lesions seldom constitute a problem of resuscitation, they too will be excluded from the discussion.

Secondary injuries may be due to falling, or to an object dislodged by the convulsing victim. They may consist of any of the soft tissue injuries as well as injuries to the nervous and skeletal systems associated with force. Resuscitation is required

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only in the presence of unconsciousness resulting from brain damage, a topic which will be covered in a later paragraph.

Central nervous system effects: The central nervous system may be affected by one of two mechanisms: (1) the transmission of current through the brain, and (2) hypoxia caused by circulatory failure.

A large current is required to damage the brain. This must be transmitted from the head to another part of the body, or from one part of the head to another, passing directly through the brain.

Central nervous system damage secondary to hypoxia is associated with cardiac arrest of more than five minutes. It is manfested by unconsciousness and is sometimes associated with convulsion or apnea or both.

Cardiac effects: The transmission of current through the heart may produce (1) atrial arrhythmias (2) ventricular arrhythmias, or (3) no effects. Atrial arrhythmias are rare. Morgan and others (1) have described atrial fibrillation and its treatment following electrical shock. The symptoms, diagnosis, and treatment of this condition are no different from atrial arrhythmia from other causes.

Ventricular arrhythmias, on the other hand, are a serious problem. Currents ranging between 25 and 75 milliamperes—the current involved in lighting a $2\frac{1}{2}$ to $7\frac{1}{2}$ watt light bulb—will cause a transient asystole followed by a ventricular beat on cessation of the current. Currents from 75 milliamperes to 4 amperes (the equivalent of the current flowing through a $7\frac{1}{2}$ to 400 watt bulb) cause ventricular fibrillation—a fatal arrhythmia. Currents greater than 4 amperes produce asystole, sometimes followed by a normal sinus rhythm on cessation of the current but may be followed by asystole.

Treatment

As stated above, the treatment of burns, or injuries due to muscular contraction, and secondary injuries caused by electrical shock does not constitute, by strict definition, resuscitation. For that reason, this discussion will be limited to a description of the treatment of the effects of electric shock on the central nervous system and the heart.

Coma

The treatment of a comatose patient who is breathing and has normal cardiac function following an electrical shock should center on damage to the central nervous system. The first requirement is the maintenance of good oxygenation. The respiratory center in these patients may be depressed, convulsions may have caused vomiting and aspiration, and the patient's position may be such as to impede normal respiration. Mouth-to-mouth respiration is the preferred method of artificial ventilation. This is simple, easy to administer, and effective.

The next most important and urgent consideration is the evaluation of the damage. Evidence of injury to the skull from external trauma should stimulate observation for intracranial bleeding. Treatment should be instituted if this condition is suspected, and, as in all hemorrhage, consists of hemostasis. This, of course, means craniotomy. Craniotomy and decompression of the brain for edema associated with brain injury is a controversial question, but it should always be considered in the comatose patient who does not have an obvious localized lesion, but is losing ground. Arrhythmias

The treatment of atrial arrhythmias consists of quinidine for atrial fibrillation, and digitalization or vagal stimulation for atrial tachycardia. These arrhythmias are not particularly serious.

Ventricular arrhythmias are serious. There are two varieties-fibrillation and standstill. Some measures in the treatment of ventricular arrhythmias apply to both. It is impossible to revert to a normal ventricular rhythm without adequate pulmonary ventilation. In the early phase of resuscitation and during the entire time the chest is open, this is achieved by artificial respiration. In the absence of any equipment, the preferred method is mouth-tomouth breathing. The technique consists simply of blowing into the mouth of the patient, whose nose is held closed. This method is simple, effective, and does not tire the "respirator." The second requirement of all patients with cardiac arrest, whether from electrical shock, surgery, or spontaneous ventricular arrhythmias, is the administration of digitalis in effective doses, preferably by the intravenous route. It is well known that after cardiac arrest hearts are subject to failure. Calcium is also useful for increased contractility of the heart.

The other common treatment for both of these lesions is manual systole. As soon as the diagnosis of cardiac arrest is made, the thoracic cage should be opened in the left fifth interspace (just beneath the pectoralis muscle in the male) and a wide intercostal wound made as quickly as possible. The presence of arterial bleeding in this wound indicates a mistaken diagnosis, and because people with cardiac arrest bleed very little, the wound should not be carried through the chest until the status of the circulation is re-assessed. The fourth and fifth costal cartilages should then be divided and the hand inserted into the chest.

In his emphasis on the heart, one should not forget ventilation of the lungs, which by this time should have been reinstituted by mouth-to-mouth respiration, endotracheal tube, or tracheotomy. Once the chest is opened, the heart should be massaged without attempts to differentiate ventricular fibrillation vs. ventricular asystole, because the patient's most urgent need of the moment is adequate circulation, which massage will afford. Manual systole should be active and hard, with active relaxation of the hand so that the heart can fill. The heart cannot fill well if it has to push the hand ahead of it. A rate of 80 to 100 should be maintained, and the ventricle should be emptied with each stroke. If massage is begun early enough, most hearts in asystole will begin to beat after a few strokes. If this is accomplished, no other maneuver should be carried out.

After one to one and one-half minutes of massage, if the heart has not started to beat, the pericardium should be opened. This measure has two purposes: (1) to improve manual systole with the hand inside of the pericardium and around the ventricles; (2) to make the diagnosis of ventricular fibrillation or ventricular asystole. The pericardium should be opened widely in a superior-inferior plane and retracted around the heart. The phrenic nerve should be saved. A paralyzed diaphragm might seem trivial as compared with the saving of a life, but it is easy to preserve the phrenic nerve and prevent the threat of a nonfunctioning diaphragm in

the postoperative course. After the pericardium is opened, without looking (because a few seconds of circulatory arrest have passed) the heart should again be mastherapy and antibiotic therapy were caused ute is sufficient. Then the heart should be observed to establish the nature of the rhythm. An obviously "squirming" heart is one which is in ventricular fibrillation. The dilated, flabby heart is usually in asystole, and should be treated as such. Sometimes the fibrillation cannot be seen, and a mistaken diagnosis of ventricular standstill is made. After a few minutes of active manual systole, however, the fibrillation will usually become detectable.

Depending on the facilities available, one of three courses can be taken in the treatment of ventricular fibrillation. On rare occasions simple cardiac massage and oxygenation of the myocardium will cause reversion to a normal sinus rhythm. In the absence of any facilities, this method must be depended upon until other facilities are available. In the presence of a defibrillator, tablespoons and wire, or other materials for application of alternating currents to the heart, electrical shock is the best method for defibrillation. Current should be applied across the heart at one-second intervals, usually three jolts per application, 110 volts alternating current out of the wall outlet. Failure of the first application should be followed by further massage. The fibrillating heart will not revert to a normal rhythm during hypoxia, and the only solution, even when the best of defibrillators is available, is oxygenation before defibrillation. In the absence of equipment for defibrillation, the heart can be stopped by injecting a 2½ per cent solution of potassium chloride or potassium citrate into the left ventricle. The usual requirement is 10 to 20 cc. injected in 10 cc. increments, followed by active cardiac massage to maintain the circulation and get the drug into the coronary arteries. Success with this method produces asystole, after which manual systole should be maintained until the myocardium is washed free of the potassium solution. A normal sinus rhythm will usually follow.

Ventricular asystole is treated by manual massage, atropinization, and, if a pacemaker is available, by stimulation of ventricular contractions. Any instrument which will administer a variable voltage between 10 and 150 volts in spikes of current at a rate of 80 to 120 will do. Most nerve stimulators and all cardiac pacemakers have these specifications. External pacemakers are available and should be used when at hand. Prolonged external stimulation is distressing to the patient but is easily circumvented by passing a cardiac catheter filled with a stylet into the right ventricle. Heparin must be given in conjunction with this procedure in order to prevent the formation of clots on the catheter. External stimulation should be used until the device can be inserted.

Atropinization is important. Hyperactivity of the vagal system can cause bradycardia and prevent reversion to a functional rate. Large doses are used to block the vagus completely. Two to 8 mg. (1/32 to 1/8 grain) are not excessive.

The problem of how long to massage the arrested heart always comes up. If oxygenation and circulation appear adequate, massage should be continued for hours, or until the heart is "worn out." Evidence of adequate oxygenation and circulation is sometimes difficult to evaluate. Certainly a conscious patient or one with reflexes deserves continuation of massage. We personally know of one person who is doing well after 80 minutes of flat electroencephalogram.

We should not forget that the stubborn heart asystole should be treated by electrical shock. This practice will defibrillate an occasional heart that is in fine fibrillation and appears to be in asystole. Post-arrest care: The thorax should be closed with the lung expanded and with a thoracic drainage tube in place. The thorax should be carefully closed in layers. Antibiotics should be administered, and adequate ventilation should be maintained. The duration of cardiac and circulatory arrest can well be long enough to depress the respiratory center, allowing the patient to breathe but not adequately. In this event, breathing should be supplemented by mouth-to-mouth respiration or with a respirator through an endotracheal tube or tracheotomy. Comatose patients should have a tracheotomy.

Coma in a patient following cardiac arrest does not warrant abandonment. Good supportive care, adequate pulmonary ventilation, and maintenance of cardiac function can keep some of these patients alive until their cerebral lesions heal, and allows them to awaken and live normal lives.

Summary

The most important aspect of resuscitation following electrical shock is the treatment of fatal cardiac arrhythmias—namely, ventricular fibrillation and standstill. Treatment of these conditions consists of maintenance of adequate pulmonary ventilation and reversion to a normal sinus rhythm by one of the appropriate methods which has been discussed.

References

- Murgan, Z. V., Jr., Headley, R. N., Alexander, E. A., and Sawyer, C. G.: Atrial Fibrillation and Epidural Hematoma Associated with Lightning Stroke, New England J. Med. 259:956-959 (Nov. 13) 1958.
- Hughes, J. P. W.: Emergencies in General Practice: Electric Shock and Associated Accidents, Brit. M. J. 1:852-855, 1956.
- Barrera, S. E.: New Medical Physics. Vol. 1. Edited by Glasser, O. Chicago, Year Book Publishers, 1944.

Failure to instruct a patient to return to his usual occupation is the commonest form of mismanagement which annuls his resolve to place his illness behind him and which undermines the very happiness of his home. When advocating a return to work it should be emphasized that such work must be customary work. The urge to move a patient from one occupation to another cannot be too strongly condemned; a change of occupation at this time means unsettlement, not resettlement.—Evans, W.: Faults in Diagnosis and Management of Cardiac Pain, Brit. M.J. 1:252 (Jan. 31) 1959.

A Clinical and Laboratory Study of Combined Mendelamine and Thiosulfil in Resistant Urinary Tract Infections*

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This study was begun about six years ago purely as a clinical trial. It involved old and time-honored forms of therapy which, since the advent of miracle drugs, had almost been forgotten.

More than 40 years ago, methenamine, which by virtue of formaldehyde liberated in an acid urine, was known to have bactericidal properites in the urine and on the surface of uroepithelium, and was the only proved urinary antiseptic of its time.

About 20 years later ketosis in a diabetic patient with chronic urinary infection was inadvertently found to wipe out a previously intractable infection. Thus a ketogenic diet later followed by mandelic acid became the most effective therapy as proved by its efficacy in lowering the pH of the urine in combating chronic urinary infection.

It is generally recognized that methenamine and acidifying drugs act almost entirely within the urinary stream and have no virtue proximal to the collecting tubules. Other drugs such as sulfonamides and antibiotics exert most of their effect in the blood stream and urinary tissues, and though excreted at varying concentrations in the urine, have minimal effect therein.

With this knowledge as a base for clinical experimentation, we decided to attempt the combined use of drugs which act in the affected tissue and those which are bactericidal in the urine. The need for such a combination appeared to be greatest in chronic recurrent infections, particularly those due to bacillary organisms, which have become more common since the advent

of antibiotics. The everchanging fight of the newer and more potent chemotherapeutic agents and antibiotics against the more resistant strains of bacteria is difficult enough in new, acute, and uncomplicated infections, aside from the chronic and recurrent types in which organisms have become resistant to drugs and in which various uropathies such as obstruction and foreign bodies play a part. It is our belief that recurrent bouts of infection are quite commonly ascending infections resulting from stagnation. Futhermore, a method of attack which can be long continued and which will sterilize the urinary stream while acting within the tissues appears to offer the best hope of success.

The cost of antibiotics for prolonged therapy, together with the lack of broad spectrum quality and, even more important, their tendency to produce an overgrowth of resistant strains, militated against their use in this experiment. A sulfonamide, if found to be safe for use in acidified urine, appeared to be the most desirable chemotherapeutic agent to try in combination with methenamine and an acidifying drug. At this time we were using several highly soluble and relatively non-toxic sulfa drugs which had appeared on the market. The one which impressed us in our experience as being least toxic and least likely to block the kidney tubules in a low pH medium was Thiosulfil. If this impression proved to be true, its low cost and broad spectrum, as well as its relative immunity to development of bacterial resistance, would suggest its selection as the agent for trial in combination with Mandelamine (methenamine).

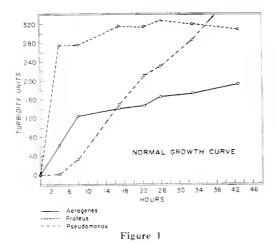
Method of Clinical Trial

In selecting chronic cases for the use of combined Thiosulfil and Mandelamine, none was used that had not proved to be resist-

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^{*}With the technical assistance of Robert G. Jackson, Wake Forest College, Winston-Salem.

This study was made possible through the financial assistance of Ayerst Laborstories, 22 E. 40th Street, New York, N. Y., who also furnished the drug used AY 5803.



ant to an adequate trial of various sulfonamides and antibiotics. Most of the organisms were gram negative bacilli, many of which were urea splitters. Furthermore, the infection was frequently complicated by stones and obstruction.

The dosage used comprised 0.5 Gm. each of the two drugs administered four times a day. No attention was given to water intake, and the only dietary restriction was of alkalies and citrus fruits. On this regimen 500 to 600 selected patients have been treated without any untoward effects such as acidosis, toxemia, or urinary blockage. The results varied, some patients responding promptly while others required quite long-continued therapy. The results as a whole were better in our hands than with any single drug, and were quite often dramatic. Our greatest satisfaction came in the successful eradication of Proteus and Pseudomonas infections following surgical removal of triple phosphatic stones in many cases, thus preventing rapid recurrence of stones.

Since this paper is primarily a report on laboratory studies regarding the factors and mechanisms responsible for the good results obtained, time does not permit a detailed discussion of the individual cases in our clinical series. Such a paper will probably be published eventually.

Method of Laboratory Experiment

In our clinical experience, infections that proved most intractable to varied chemotherapy and antibiotic therapy, were caused

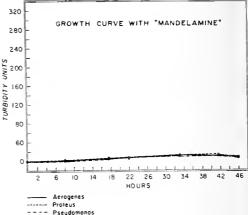


Figure 2

by Proteus, Aerobacter and Pseudomonas bacilli. For this reason, these bacteria were selected for our laboratory experiment. They were selected from patients with chronic, longstanding infections resistant to all previous therapy.

Sensitivity studies by means of the disc method revealed resistance in each type to penicillin, dihydrostreptomycin, tetracycline, chloramphenicol and nitrofuran. Sensitivity studies to sulfaonamide preparations were not done. Sub-cultures were planted in tripticase broth (30 Gm. of broth diluted to 1,000 mm3 with distilled water).

Twenty-four hour collections of urine were obtained from four healthy males, who were taking no medication or special diet. The four specimens of urine were

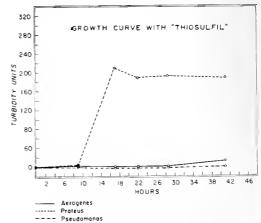


Figure 3

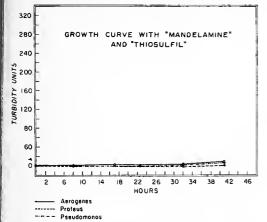


Figure 4

combined and filtered through porcelain candles for purposes of sterilization. This urine was used as a diluent for the "normal" growth of bacteria.

Our first plan was to apply the chemotherapeutic agent directly to the urine containing the bacteria. We encountered difficulty in producing a true solution of the urine of low turbidity with direct mixing particularly with the Thiosulfil. Accordingly, we turned to human metabolism for a clearer diluent and better solution of the chemotherapeutic agent. This was accomplished by giving the four urine donors clinical doses of the medication involved.

Each donor was given 0.5 Gm. of Mandelamine orally every six hours for a total of four doses. On the morning following administration of the drug, their first voided specimens were collected, combined, and filtered through the porcelain candles. The urine was used as a diluent for experiment (fig. 2).

After four days the same male donors were given four doses of 0.5 Gm. of Thiosulfil at six-hour intervals, and the first morning specimens following this medication were collected, combined, and filtered. This urine was used as a diluent in experiment (fig. 3).

The four males were next given a combination of 0.5 Gm. of Mandelamine and 0.5 Gm. of Thiosulfil orally at six hour intervals for a total of four doses. On the following morning the first voided specimens were collected, combined and filtered, and used as a diluent in experiment (fig. 4).

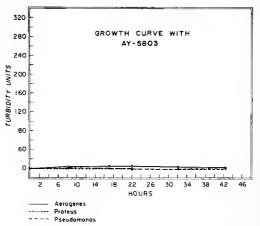


Figure 5

For the final experiment, the four male urine donors were given two tablets of AY 5803* at six-hour intervals for a total of four doses. The first voided specimens the following morning were collected, combined, filtered and used as a diluent in experiment (fig. 5).

A typical experiment was conducted as follows: 0.1 milliliter of bacteria (diluted 1:100 with sterile broth) was diluted to 5.0 milliliters using donor urine as a diluent. This was done in triplicate. The pH was determined before and after addition of the organisms and was found to be below pH 6.35 in all the specimens used. The test tubes were placed in a Klett turbidometer and turbidity readings were recorded. The specimens were then incubated at 39 C. for various periods of time, and at appropriate intervals turbidity readings were obtained and recorded.

The results obtained in each experiment are represented by a graph. Plotting points in each case represent an average of the triplicated experiments, and all turbidity readings were adjusted to an initial reading of zero for purposes of clarity and comparison. Graph lines, therefore, represent an actual deviation from the initial turbidity.

Results

The rate of growth of the organisms in the presence of "normal" urine is represented by figure 1. Increase in turbidity

^{*}The AY5803 is a combination of Mandelamine and Thiosulfil furnished by Ayerst Laboratories, 22 E. 40th Street, New York, N. Y.

was remarkably inhibited in the presence of urine containing Mandelamine alone (fig. 2). Urine containing Thiosulfil alone (fig. 3) inhibited growth of Aerogenes and Pseudomonas organisms, but merely delayed the growth of Proteus for a period of nine hours. Growth of the organisms in the presence of urine containing both Thiosulfil and Mandelamine was inhibited very satisfactorily (fig. 4), and compared favorably

with the results obtained in using the combination AY 5803 (fig. 5).

From the results obtained, we believe that the use of combined Mandelamine and Thiosulfil (AY 5803) offers great promise of effectiveness in the management of resistant infections of the urinary tract. This usefulness is further enhanced by the low toxicity, relative freedom, from side effects, ease of administration, and real economy in long term therapy.

The Psychologic Effects of ACTH and Cortisone Therapy

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The hormones of the adrenal cortex, known collectively as steroids, are comprised of estrogen and progesterone derivatives, 17-ketosteroids, and the corticosteroids or C₂₁ compounds. Of the more than 30 corticosteroids, only 6 are known to possess significant physiologic activity in humans. ACTH produced by the anterior pituitary gland is known to control the secretion of 5 of these 6 hormones. The sixth, aldosterone, is thought to be secreted independently of ACTH stimulation, perhaps in direct response to hypothalamic stimulation.

In humans, the adrenal cortex secretes mostly hydrocortisone, with lesser amounts of cortisone and still smaller amounts of the remaining hormones. The peripheral action of cortisone and hydrocortisone, however, is very similar, with the exception that hydrocortisone is more active metabolically and exerts greater effects on the feed-back mechanism affecting ACTH secretion.

Among its many physiologic and pharm-acologic actions, cortisone accelerates protein catabolism; alters carbohydrate metabolism by increasing gluconeogenesis and decreasing peripheral utilization of glucose; affects water and electrolyte metabolism; enhances the body's response to stress, and inhibits the inflammatory response. Thus in recent years both ACTH and cortisone

preparations have been employed in the treatment of an increasing number of conditions, including the collagen diseases, allergies, certain blood dyscrasias, ulcerative colitis, and nephrosis, and as replacement therapy for adrenal insufficiency, to mention only a few. The use of this drug, however, is not without hazard: such untoward effects as electrolyte disturbances, osteoporosis, hypertension, psychologic changes, and depression of adrenal cortical function upon withdrawal are frequently seen.

Classification

Psychologic changes are frequently noted in patients treated systemically with therapeutic doses of ACTH or cortisone. The psychologic effects are entirely unpredictable in any given patient, but may be grouped into two broad categories—the minor reactions or mood changes (both positive and negative) and the major mental disturbances or psychoses. Mood changes are much more common than major mental disturbances, which occurred in 4 per cent of the cases in the 16-author series recorded by Ritchie⁽¹⁾ (table 1).

Mood Changes

Positive mood changes have been extremely difficult to assess, because the sudden relief of pain brought about by a temporary remission of symptoms of the underlying disease often results in a feeling of well-being. This feeling, however, frequently precedes the relief of symptoms or is entirely out of proportion to that ex-

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Table 1*
mary of Published Series With Mental Reactions Under ACTH or Co

		Summar	y of Published	Summary of Published Series With Mental Reactions Under ACTH or Cortisone	actions Under A	ACTH or Cortisone		
Author	Year	Drug	Total No. Cases	Disease	Treatment Duration	Affective State Bunhoria Hynomanic Denressiva Stuncy Denabases	Denressive Stuner	Detroboses
Boland, EW	1951	೮	16	Rheumatoid arthritis	6-15 mos.	2	orpressive outpot	r sychoses
Ward, E	1951	O	100	Rheumatoid arthritis	long term	59		
Lidz, T	1951	A&C	15	Various, but in 10 cases of	8-38 days	4	67	Ø
Glaser, GH	1953	A&C	006	asthma	0			
Levin, MH	1953	A&C	20	arthritis	18 mos		Н	10
Taran, LM	1953	A&C	16	Rheumatoid	Long term	9	ಣ	ıa
Copeman, WS	1954	C	20	cardius Rheumatoid arthritis	Long term		1	
Engleman, E	1954	C	99	Rheumatoid	4-38 mos.	6		
Kirsner, J	1954	A	120	artinus Ulcerated	1-4 yrs.	53	13	∞
McGehee, EH	1954	A&C	185	Various	Long term			•
MRCPanel	1954	A&C	124	Skin disorders	Short term	6		no (
Trethewan, W	1954	A&C	17	Rheumatoid		-	-	% 6.
Bunim, JJ	1955	C	78	Rheumatoid	Up to 4 yrs.		4	
Fox, HM	1955	A&C	100	Various	Som ?			;
Pearson, JE	1955	Ą	10	Asthma	Short-term	-		16
Toone, EC	1955	၁	35	Rheumatoid	Up to 3 yrs.	1		-
				2777777				•

*From Ritchie, E. A.: J. Ment. Sc. 102:830-837, 1956.

pected from relief of symptoms. Moreover, patients with less crippling lesions such as ulcerative colitis or pneumonia experience the same degree of mood change as those with more painful and less rapidly responding diseases, such as rheumatoid arthritis or lupus erythematosis. Thus the percentage of patients experiencing a significant positive mood change, that is, inappropriate for the degree of physical improvement, varies tremendously from an insignificant figure to nearly 100 per cent(2) with many authors reporting in the vicinity of 50 per cent. Rome and Braceland(3) reported 60 per cent in their series of more than 100 cases. When the feeling of well-being progresses to euphoria, however, the figures are somewhat more reliable, and according to table 1, euphoria or hypomania occurred in 76 of 1,202 cases, or 6.2 per cent.

The positive mood changes frequently reported are a feeling of well-being, increased alertness and keenness of perception, increased appetite, added physical and intellectual energy, marked clarity of thinking, renewed interest in surroundings, and greater capacity for emotional relationships.

In a case reported by Browne⁽⁴⁾, a philosophy professor who had panhypopituitarism and had been under treatment with thyroid and testosterone for many years suddenly experienced "renewed energy," "less need of sleep and rest," and the ability to read three philosophy books per day (whereas previously he would not read any) when ACTH and cortisone were added to his regimen. His intelligence quotient did not alter under treatment, but his rate of speech and reaction were altered, and he had a greater degree of communication. Browne also published a series of "selfportraits" of patients undergoing treatment. In general, as positive mood changes reach their zenith, the patients show a greater degree of masculinity or femininity, depending on the sex of the individual. Browne interprets this response as meaning that ACTH or cortisone brings out more intensively hidden components of an individual's psychologic make-up. Cleghorn'5', however believes that new components may be induced by the action of the drugs.

Positive mood changes occur more frequently than do negative ones when a single mood change occurs, according to Sprague⁽⁶⁾, Hench⁽⁷⁾, and Frank⁽⁸⁾. These authors also state that such changes as occur are usually temporary and transient.

Negative mood changes are manifested by anxiousness, restlessness, irritability, inability to concentrate, and anorexia, sometimes progressing to negativism, withdrawal, frank depression, feelings of unreality, depersonalization, and psychotic behavior. These changes sometimes occur initially, but often follow a brief up-swing mood, the sequence being feelings of well-being, elation or euphoria, irritability and insomnia, depression, and psychotic behavior. Most negative mood changes are transient and usually disappear with cessation of treatment, although a few persist.

Psychoses

Psychoses developing during or following cortisone or ACTH therapy are extremely protean in character⁽¹⁾. They include disturbances of speech and affect, delusions, hallucinations, paranoid tendencies, depersonalization, disorientation, and sensorial disturbances. Psychoses are nearly always preceded by a milder form of mood disturbance.

Glaser(9) and Kelleher(10) both agree that these psychotic reactions can be of two basic types-affective or organic-but from this point on they disagree and even contradict each other, as do most authors who have studied the problem. Glaser, in his series of more than 200 cases including 10 psychoses, describes a primarily affective disorder and a more complex reaction called a toxic psychosis. He reports that in his series, the manic psychoses seemed to develop within several days after initiation of treatment, and that mild or hypomanic reactions seemed to be self-limited with cessation of treatment; but in full manic storms, electroshock therapy was needed to terminate the condition. The toxic psychoses were characterized by deliroid manifestations, with confusion, clouding of consciousness, disorientation, memory lapses and other sensorial defects, hallucinations, often with paranoid manifestations, and an affective component frequently depressive. Occasionally this type resembles the schizophrenic state, and a certain number of these patients had psychotic tendencies

prior to treatment. This reaction may appear at any time during treatment (six days to two months), has no constant relation to dosages, and is extremely variable in duration (1-35 days).

Kelleher and Sneddon(10) concluded from their 3 psychotic patients that in cases of the organic type, the symptoms and content are foreign to the pre-psychotic personality, that there is no history of previous mental illness or susceptibility to such, that the degree of reaction is altered by varying dosages of hormones, that sedation often controls the episode, that the condition abates rapidly when treatment is stopped, and that there is often complete amnesia for the episode. On the other hand, in the affective type, the form is determined by the pre-psychotic personality, a predisposed person, the content is extremely variable in terms of previous personality strivings, and the often continues after cessation of therapy. The sequence is often euphoria to hypomania to mania to malignant psychosis, and EST is often needed for termination.

Levin⁽¹¹⁾, in his series of 50 patients with 5 psychoses, describes the psychotic behavior as being manic-depressive in 2 and paranoid schizophrenic in 3. These reactions occurred anywhere from 10 days to two or three months after treatment was begun, and psychotic behavior ceased shortly after withdrawal of the hormones. All of these patients had an unstable personality before treatment.

Fox⁽¹²⁾, in his series of over more than 100 patients, described psychotic-like disturbances in 14 per cent of the cases. These patients all had disturbance in mood, thinking, and reality perception, but only 1 exhibited the clouding of consciousness, disorientation, or intellectual deficit characteristic of organic confusional states.

Goolker (13), in his series of 80 patients, reported that 15 per cent showed distinctly aberrant reactions of depressive, paranoid, schizophrenic, or toxic type. Most of these episodes were transient, mild, and self-limited.

Rome and Braceland⁽³⁾, in their series of more than 100 cases, reported grossly psychotic behavior in 10 per cent, and most of these patients had a history of previous psychiatric illness. The episodes were of brief duration and the majority subsided

spontaneously within a few weeks after treatment was terminated. The most striking responses to ACTH and cortisone were in the sphere of affect, changes were not correlated with potassium levels, and patients with Addison's disease showed a greater vulnerability than others.

Clark⁽²⁾ reported on 10 patients, 4 with minor and 6 with major mental disorders. Of the major disorders, frequent findings were perceptual disorders, speech disturbances including flight of ideas, tangentiality, stereotype, delusions, and affective disturbances ranging from depression to hypomania to grossly inappropriate affect. In general, these patients did not exhibit the type of confusion, disorientation, and sensorial disturbance regarded as characteristic of toxic delirium.

Withdrawal Reactions

Withdrawal of cortisone or ACTH can also result in mood alterations mainly characterized by a sense of emptiness, depression, decreased appetite, and a feeling of loss of emotional contact. Freyberg(14) describes a withdrawal syndrome in 21 per cent of his 44 patients treated with ACTH and cortisone for rheumatoid arthritis. These episodes lasted longer than did the indications of suppressed adrenal function, but always subsided in two to eight weeks. According to Lidz 115, Dutoit and Bauer describe depressions occurring during and after therapy which ended in suicide. Ritchie(1) also points out the risk of suicide during withdrawal.

Correlation of Reaction With Therapy

Numerous investigators have attempted to correlate the psychologic changes occurring during ACTH and Cortisone therapy with many factors such as dosage levels and 'duration of treatment, potassium levels, electroencephalographic changes, convulsions, external stresses, somatic symptoms. underlying disease basic personality structure, and previous mental illness. Most of the conclusions which have been drawn from these studies, however, are inconsistent, contradictory, and disappointing.

Most investigators agree that high dosages and prolonged treatment are important factors in the development of psychoses, but these factors are not correlated with the time required for development of the psychoses or with their severity. Also,

Table 2 Cases of ACTH and/or Cortisone Psychoses at Duke Hospital Reported to October, 1957

	Other	K 2.8 CO., 32.1 Rx K; psychotherapy	EEG normal Rx K; chloral hydrate		Had moon face		Convulsions associated with ahortion 11/11	EEG normal No electrolyte imbalance			
Development Total of	Predisposition	Previous emotional stress and anxiety for 1 yr. PTA	II. of Jacksonian Convulsions and intracranial bleeding (1 yr. PTA)	Hospitalization for paranoid tendencies (1943) Rx 15 electroshock treatment	c-•	Social withdrawal over period of 12 yrs.					
	Diagnosis	Transient psychotic cpiside related to cortisone and mild hypokalemic alkalosis; acute brain syndrome depressive reaction	Acute brain syndrome, drug intoxication para- noia	Psychotic reaction due to cortisone	Cortisone intoxication with manic psychosis	Not recorded	Acute brain syndrome with drug intoxication (ACTH); delirium	Toxic psychosis, ACTH	Toxic psychosis due to withdrawal of Cortisone; acute brain syndrome		
	Dosage Psychoses Recovery Diagnosis	7/20 7/22	1/17 1/19 much improved	8/26 9/23 Psychotic re overt discharged to cortisone	? only partial in 4 days	2/14 5/19 overt discharged	1/3 11/14 disc 11/19 e sl. euphoria	12/11 12/18 discharged	shortly 5/31 prior improved to adm. 6/11	o/ 50 discharged	
		725	1,670 2,000 220	2,375 { (approx- cimately)	٠٠	105	1,000 1 (estimated)	320 200	200 sl mgqd F	250 300 q d	00
Duration of	Treatment	7/14-7/20 + unknown amt. PTA.	12/51-12/52 8/11-12/28/52 1/10-1/18/52	7/5-8/1/51	Approximately 1 yr.	2/5-2/9?	10/6-11/2	$\frac{11}{24 \cdot 12}$	4/15(?)-5/29 (tapered last 2 wks.)	5/30-6/2 6/3-	History #C76700
	Case Age Drug Disease	Shoulder pain; chole- lithiasis	1TP (Exploratory lap. 1/15)	Dermatitis herpetiformis	Rheumatoid arthritis	Rheumatoid arthritis	? Boeck's sarcoid	Seleroderma 11/24-12/9 12/11	Hodgkin's disease; ac- quired hemo-	lytic anemia	Chart Unavailable
	Drug	r.	40 K	Ü	0	Κ.	¥	ΨO.	ပ	00	ในฉขอ
	180	1. WF 58	÷	7	1 53	33	31	<u>s</u>	** **		urt L
	ese	WF	WE	WF	WM	WF	CF	CF	W F		
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most workers, including Clark(2) and Glaser(9), state that psychoses have developed often enough in patients receiving comparatively little treatment to make it likely that other factors are involved. Hench⁽⁷⁾ states that 200 mg. of cortisone four times daily or 100 mg. ACTH should be considered as "high" dosages which may be well tolerated by most patients for fairly short periods of time only, and should be considered suitable only for short-term use or emergencies. Continued tolerance for daily dosages of 100 mg. of cortisone or 50 mg. of ACTH is much greater, but smaller effective dosages should be used whenever possible.

Physiologic Basis of Psychic Changes

The vast majority of investigators are generally agreed that there is no consistent correlation between psychotic states and electrolyte alterations (9). Recently, however, it has been thought that potassium depletion may be important. Ransohoff(16a) reports the case of a hypertensive patient undergoing treatment with ACTH for experimental purposes in whom an acute toxic psychosis developed with paranoid features that returned to normal on treatment with potassium without cessation of ACTH. Torda and Wolf(16b) also found that the tendency of some patients to develop malaise, headache, and insomnia while under treatment with ACTH was decreased when potassium was administered.

Although electroencephalographic changes are frequently seen in patients undergoing treatment with ACTH and cortisone, there are no consistant relationships between these changes and the appearance of psychotic reactions. Hoefer and Glaser (17) reported significant abnormalities consisting of a slowing of rate in 13 of 15 patients undergoing treatment, correlated with alterations in personality in 10. Ransohoff(14) reported patients with slowing of activity that responded to correction of electrolyte imbalance. Glaser (9) reported 4 cases of psychoses with diffuse slowed activity, but many patients with changes in electroencephalographic patterns but no mental disturbances were also observed. Lidz(15) reported a negative correlation between EEG and behavioral changes.

Dorfman⁽¹⁸⁾ reported 3 patients with various diseases who began to have seizures

with evidence of damage to the central nervous system after treatment with ACTH. In 2 patients, the convulsions were preceded by toxic delirious reactions, but in none was there a "serious" disturbance of electrolytes. Elkington⁽¹⁹⁾ and Soffer⁽²⁰⁾ also reported convulsions occurring in patients under treatment, but the majority of investigators have not found this to be a complication of treatment.

McLaughlin⁽²¹⁾ thought that there may be a relationship between the emotional responses of patients and the stresses under which they were living when treatment was instituted, but other investigators have not supported this concept.

Braceland and Rome⁽³⁾ observe that emotional changes are most striking in those patients who experience abrupt and dramatic physical improvement. They postulate that latent psychologic conflicts may be exacerbated with the abrupt removal of somatic symptoms that have served the purposes of primary or secondary gain. This may so tax the individual's resources of psychologic adaptation that psychotic behavior results. Thus, ACTH or Cortisone can jeopardize an individual by destroying the defenses which are the keystones for the maintenance of his stability. Brody⁽²²⁾ agrees with this concept.

Other investigators state that frank psychoses due to ACTH or Cortisone therapy are rare, and Lidz(15) quotes Thorn as saving that in his experience, they developed only during the treatment of diseases known to produce organic changes in the central nervous system. It has been observed that patients with collagen diseases, particularly disseminated lupus, seem most susceptible to psychotic reactions, possibly because the widespread vascular disease affects the central nervous system as well as other organs. Weinberg(23) states that the physician may have great difficulty in distinguishing between a spontaneous psychosis arising during the course of a disease like lupus, and the mental symptoms directly attributable to ACTH or cortisone. Ritchie(1) holds that collagen diseases and Addison's disease render subjects more vulnerable to mental disturbances than do other diseases, but in general the complications of cortisone and ACTH therapy are similar for the great majority of conditions for which these hormones are employed.

Brody (22) believes that the particular psychodynamics of the individual personality determine to a great extent the emotional response elicited by ACTH or Cortisone. In his series, behavior during treatment reflected the usual reaction pattern of an individual or an exaggeration of it. Glaser (9) states that the premorbid personality determines the psychologic content of the psychosis, but not its onset.

Ritchie places great emphasis on the past history of mental illness, and Dunlop(24) finds that cortisone exaggerates neurotic, psychotic, or epileptic tendencies, and should be employed only for very compelling reasons in patients with an unstable mental background. Ritchie quotes Copeman as saying that he regards present or past psychosis as an absolute contraindication to cortisone or ACTH therapy. On the other hand, none of Clark's(2) 10 patients manifesting mental changes had any history of previous mental illness. And, in a series of 12 patients with a history of recent mental illness treated with ACTH and cortisone by Lewis (25), none developed severe mental illness during treatment, and such illnesses as occurred could be accounted for as responses to changes in physical symptoms present prior to treatment. Lewis thus concludes that the predisposition to develop untoward mental symptoms under treatment can not be assumed in patients with an unstable neurotic personality or a history of mental illness.

Summary and Conclusion

Very little is known about the mechanism of ACTH and cortisone on brain metabolism. According to Himwich(26), these hormones disturb enzymatic reactions by altering the electrolyte and water pattern of the body, thus changing the physicochemical environment in which the enzymes operate and altering cerebral energy transformations. Also, the corticosteroids may affect enzyme systems directly, a fact of great significance since the blood brain barrier is permeable to steroids. Therefore, he postulates the existence of a chemical causative agent that pathologically stimulates selectively various higher, especially perceptive, brain centers, with the result of hallucinatory and delusional experiences.

Thus, in summary, we see that mood changes associated with ACTH and corti-

sone therapy are extremely common. When one change occurs, it is usually mild and in a positive direction. Negative mood changes sometimes occur initially, but more often follow a positive change. Psychoses are rare, and usually follow minor mood disturbances; they are extremely protean in nature, and include disturbances in perception, affect, speech, and thought, as well as delirium. Psychoses usually terminate spontaneously with cessation of treatment, but may be associated with depression and suicide on withdrawal. There is no consistent relationship between psychotic behavior and duration of treatment or dosage, but prolonged treatment and heavy dosages should be avoided. Changes in electrolyte balance and electroencephalograms have been noted, but there is no consistent correlation among these factors. Convulsions have been reported in a few instances. Predisposed personality, previous mental illness, underlying disease process, and disappearance of somatic symptoms which serve some purpose have been implicated, but not proved to affect the onset or course of psychosis.

In conclusion, it would seem that ACTH and cortisone do have a direct effect on the central nervous system, and that their overall action is to heighten perception, perhaps as a part of a readiness for action. It would seem that cerebral stimulation is the early result of the psychic effects of ACTH or cortisone, and that the outcome is a nonspecific and noncharacteristic psychic disturbance which is found primarily in the functional area of the ego dealing with reception of stimuli(13). That function of the ability of the ego to integrate emotional material with insight is not increased however. In fact, there may actually be a dissociation of the ego and the id, so the result is sometimes overt psychotic behavior.

Finally, let us try to bring the bi-polar views of the psychologists and the bio-chemist together into a psychobiological entity by saying that perhaps any physiological change in the internal milieu of the central nervous system evokes a mental reaction, the nature of severity of which is governed by the individual's basic personality structure and ego strength.

References

 Ritchie, E. A.: Toxic Psychosis Under Cortisone and Corticotrophin, J. Ment. Sc. 102;830-837 (Oct.) 1956.

- Clark, L. D., Bauer, W., and Cobb, S.: Preliminary Observations on Mental Disturbances Occurring in Patients Under Therapy with Cortisone and ACTH, New England J. Med. 246:203-206 (Feb. 7) 1952.
- Rome, H. P., and Braceland, F. J.: Effect of ACTH, Cortisone, Hydrocortisone and Related Steroids on Mood, J. Clin. & Exper. Psychopath. 12:184-191 (July-Sept.) 1951.
- Browne, J. S. L.: Effects of ACTH and Cortisone on Behavior: in Ciba Foundation Colloquia on Endocrinology, vol. 3, Philadelphia and New_York, The Blakiston Company, 1952.
- Cleghorn, R. A.: Alterations in Psychological States by Therapeutic Increases in Adrenal Corticotropic Hormone; in Ciba Foundation Colloquia on Endocrinology, vol. 3. Philadelphia and New York, The Blakiston Co., 1952.
- Sprague, R. G., and others: Observations on Physiologic Effects of Cortisone and ACTH in Man, Arch. Int. Med. 85:199-258 (Feb.) 1950.
- Hench, P. S., Kendall, E. C., Slocumb, C. H., and Polley, H. F.: Effects of Cortisone Acetate and Pituitary ACTH on Rheumatoid Arthritis, Rheumatic Fever, and Certain Other Conditions; Study in Clinical Physiology, Arch. Int. Med. 85:545-665 (April) 1950.
- Frank, J. A.: Acute Psychosis Developing During Therapy with ACTH, Am. Pract. & Digest. Treat. 2:400-402 (May) 1951.
- Glaser, G. H.: Psychotic Reactions Inducted by Corticotropin (ACTH) and Cortisone, Psychosom. Med, 15:280-291 (July-Aug.) 1953.
- Kelleher, J., and Sneddon, I. B.: Management of Psychotic Reactions Resulting from Cortisone and Corticotrophin, Practitioner 175:300-303 (Sept.) 1955.
- Levin, M. H., and other: Prolonged Treatment of Rheumatoid Arthritis with Cortisone and Corticotropin, Am. J. Med. 14:265-274 (March) 1953.
- Ciba Foundation, Colloquia on Endocrinology, vol. 8, The Human Adrenal Cortex, 1955.
- Goolker, P., and Schein, J.; Panel Discussion: Psychophysiological Properties of the Adrenal Cortex; Recent Unpublished Advances; Psychic Effects of ACTH and Cortisone, Psychosom. Med.; 5:588-613 (Nov.-Dec.) 1953.
- Freyberg, R. H., and others: Problems of Prolonged Cortisone Treatment for Rheumatoid Arthritis, J.A.M.A. 147:1538-1543 (Dec. 15) 1951.

- Lidz, T., Carter, J. D., I.ewis, B. T., and Surratt, C.: Effects of ACTH and Cortisone on Mood and Mentation, Psychosom. Med. 14:363-377 (Sept.-Oct.) 1952.
- 16. (a) Ransohoff, W., and others: The Effect of Sodium and Potassium on the Metabolic and Physiologic Responses to ACTH, Proc. Second Clinical ACTH Conference (Chicago, 1950), New York and Philadelphia, The Blakiston Company, 1951, vol. 1, p. 160. (b) Torda, C., and Wolff, H. G.: Effects of Administration of Adrenocorticotropic Hormone (ACTH) on Patients with Miasthenia Gravis, A.M.A. Arch. Neurol. & Psychiat. 66:163-170 (Aug.) 1951.
- Hoefer, F. P. A., and Glaser, G. H.: Effects of Pituitary Adrenocorticotropic Hormone (ACTH); Electroencephalographic and Neuropsychiatric Changes in 15 Patients, J.A.M.A. 143:620-6624 (June 17) 1950.
- Dorfman, A., and others: Status Epilepticus Coincident with the Use of Pituitary Adrenocorticotropic Hormone; Report of 3 Cases, J.A.M.A. 146:25-27 (May 5) 1951.
- Elkinton, J. R., and others: Effects of Pituitary Adrenocoricutropic Hormone (ACTH) Therapy; J.A.M.A. 141: 1273-1279 (Dec. 31) 1949.
- Soffer, L. J., Levitt, M. F., and Baehr, G.: Use of Cortisone and Adrenocorticotropic Hormone in Acute Disseminated Lupus Erythematosus, Arch. Int. Med. 86: 558-573 (Oct.) 1950.
- McLaughlin, J. T., Zabarenko, R. N., Diana, P. B., and Quinn, B.: Emotional Reactions of Rheumatoid Arthritics to ACTH, Psychsom. Med. 15:187-199 (May-June) 1953.
- Brody, S.: Psychiatric Observations in Patients Treated with Cortisone and ACTH, Psychosom. Med. 14:94-103 (March-April) 1952.
- Cares, R. M., and Weinberg, F.: Influence on Cortisone on Psychosis Associated with Lupus Erythematosus, Psychiat. Quart. 32:94-107, 1958.
- Dunlop, D. M.: Cortisone in Practice, Brit. M. J. 2:1253-1256 (Nov. 19) 1955.
- Lewis, A., and Fleminger, B.: The Psychiatric Risk from Corticotrophin and Cortisone, Lancet 1:383-386 (Feb.)
- Himwich, H. E.: Thought Processes as Related to Brain Metabolism in Certain Abnormal Conditions, J. Nerv. & Ment. Dis. 114:450-458 (Nov.) 1951.

It is clear that to the clinician the most significant characteristic of the natural history of esophageal varices which are secondary to cirrhosis is their propensity toward unpredictable dynamic fluctuations. Varices are constantly changing in diameter and extent, to the point of disappearing entirely from time to time. When only spot checks are made and examinations are carried out only during the fasting state, as in the present study, it is likely that many and major fluctuations pass unrecognized. Varices which seem static when observed at long—or even short—intervals may have undergone wide variations during the interims. It is reasonable to assume, for instance, that during the absorptive period varices are larger than they are during the hunger period, merely because of the increased volume of blood that the portal system is obliged to handle. Palmer, E. D.: Esophageal Varices Secondary to Portal Cirrhosis, Arch. Int. Med. 47:25 (July) 1957.

Evaluation of Methdilazine Hydrochloride as an Antipruritic Agent

CHARLES M. HOWELL, JR., M.D.

WINSTON-SALEM

Recently a new orally administered drug, methdilazine hydrochloride*, has proved quite effective in the relief of itching. This drug is an extremely potent antihistaminic agent with significant long-acting antipruritic characteristics. The compound has a wide margin of safety(1). It is rapidly absorbed from the gastrointestinal tract and promptly leaves the bloodstream to be bound temporarily in the tissues, where it exerts prolonged antihistaminic However, the drug is cleared from the tissues rapidly enough to limit the risk of chronic toxicity due to accumulation, without impairing its long-acting antihistaminic effect(2).

Materials and Method

Methdilazine hydrochloride was administered to 373 patients exhibiting various dermatoses in which itching was a prominent symptom. The drug was given orally in 4- to 8-mg. capsules and tablets, and in the form of a syrup containing 4 mg. per 5 cubic centimeters. The majority of adult patients (217 cases) received 4 mg. twice daily—after breakfast and at bedtime. Some patients, however, were given 8 mg. two or even three times daily at spaced intervals. Pediatric patients received 2 to 4 mg. twice daily, depending upon their age and response to treatment.

Results

The results, outlined in table 1, were tabulated according to the method of Callaway and Olansky⁽³⁾ as follows: excellent, complete relief of itching; good, substantial relief; fair, some relief; poor, no relief.

In many patients, the relief of itching was gratifying and in some cases bordered on the dramatic. For example:

1. Two patients with senile pruritus responded promptly for the first time to

methdilazine hydrochloride after having been treated with virtually every antipruritic agent imaginable, including trimeprazine. One of these patients admits to "living in fear" that he can no longer obtain the medication.

2. Thirty-two (80 per cent) of 40 children treated with methdilazine hydrochloride exhibited either substantial or complete relief of their itching. No patient in this age group failed to show some degree of improvement.

3. The most outstanding results uniformly obtained were observed in patients with chronic neurodermatitis. In many of these patients a definite tranquilizing effect was apparent. One 79 year old man has continued taking methdilazine hydrochloride twice daily for 14 months without interruption and without incident.

Side Effects

No serious side effects were observed. Minimal to moderate drowsiness was noted in 29 patients. In most instances this phenomenon disappeared with continued ad-

Table 1

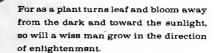
Results of Methdilazine Hydrochloride Therapy in 373 Adults (Ages 12-75 Years)

	No.				
Diagnosis		Excel	lent Good	Fair	Poor
Nummular eczema	10	4	4	2	
Chronic urticaria	20	10	6		1
Pityriasis rosea	16	4	. 9	2	1
Contact dermatitis	64	20	32	3 2 8	4
Senile pruritus	10	6	3	1	_
Hodgkin's disease	2		1	_	1
Localized					
neurodermatitis	72	30	28	10	4
Lichen planus	8	2	2	2	2
Atopic dermatitis	40	11	21	6	2 2 2
Pruritus ani	26	8	12	4	2
Pruritus vulvae	16	4	8	2	2
Papular urticaria	6	4	2	_	_
Dermatitis					
medicamentosa	16	9	4	2	1
Sehorrheic dermatitis	11	6	4	2	_
Psoriasis	10	6	4	_	_
Exfoliative dermatitis	6	1	4	_	1
Children	(Ages	2-12	Years)		
Atopic dermatitis	24	8	10	6	_
Chicken pox	4	3	1	_	_
Contact dermatitis	12	6	4	2	-
Total	373	142	159	51	21

From the Department of Medicine, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Car-

The methdilazine hydrochloride (Tacaryl R) used in this study was supplied through the courtesy of Mead Johnson and Company, Evansville, Indiana.

^{*}Chemically, methdilazine hydrochloride is 10-(1-methyl-3-pyrrolidylmethyl) phenothiazine.



BAPTABILITY.

We live in a changing world—changing, perhaps, more rapidly now than at any other time in its history. Blue Shield must keep pace with changing concepts in health care if it is to continue to perform its mission effectively. In this connection, a well-known doctor recently said: "If a doctor does not like what Blue Shield is doing, it behooves him to join up and make an effort to change the policy that governs the Plan in his community. Those who constantly complain ... and make no effort to improve ... deserve no consideration whatsoever."

BLUE SHIELD.



HOSPITAL SAVING ASSOCIATION CHAPEL HILL, NORTH CAROLINA

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VARIDASE Streptokinase-Streptodornase Lederle RICA Tablets

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Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. Varidase speeds up this normal process of recovery. By activating fibrinolytic factors Varidase shortens the undesirable phase, limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, Varidase Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

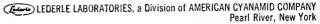
Varidase Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days. When infection is present, Varidase Buccal Tablets should be given in conjunction with Achromycin® V Tetracycline with Citric Acid.

Each Varidase Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

Supplied: boxes of 24 and 100 tablets.

1. Innerfield. 1.: Clinical report cited with permission 2. Clinical report cited with permission



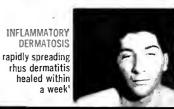


















INFECTED LACERATION marked reversal in 3 days... returned to school... closure advanced'

severe bruises

... cleared by fifth day





REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE'

Concerning Your Health and Your Income

A special report to members of the Medical Society of the State of North Carolina on the progress of the Society's Special Group Accident and Health Plan in effect since 1940

PROUDLY WE REPORT 1959

AS OUR MOST SUCCESSFUL YEAR IN SERVING YOUR SOCIETY.

During the year we introduced a NEW and challenging form of disability protection. There has been overwhelming response on the part of the membership.

Participation in this Group Plan continues to grow at a fantastic rate.

1960

is our 20th year of service to the Society. It is our aim to continue to lead the field in providing Society members with disability protection and claim services as modern as tomorrow.

SPECIAL FEATURES ARE:

- 1. Up to a possible 7 years for each sickness (no confinement required).
- 2. Poys up to Lifetime for occident.
- 3. New Maximum limit of \$650.00 per month income while disabled.

All **new** applicants, and those now insured, who are under age 55, and in good health, are eligible to apply for the new and extensive protection against sickness and accident.

OPTIONAL HOSPITAL COVERAGE: Members under age 60 in good health may apply for \$20.00 daily hospital benefit — Premium \$20.00 semi-annually.

Write, or call us collect (Durham 2-5497) for assistance or information.

BENEFITS AND RATES AVAILABLE UNDER NEW PLAN

Accidental Death	*Dismemberment		COST UNTIL AGE 35		COST FOR	AGES 35 TO 7
Coverage	Lass of Sight, Speech or Hearing	Accident and Sickness Benefits	Annual Premium	Semi-Annual Premium	Annual Premium	Semi-Annual Premium
5,000	5,000 to 10,000	50.00 Weekly	\$ 78.00	\$ 39.50	\$104.00	\$ 52.50
5,000	7,500 to 15,000	75.00 Weeklý	114.00	57.50	152.00	76.50
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.50
5.000	12,500 to 25,000	125.00 Weekly	186.00	93.50	248.00	124.50
5,000	15,000 to 30,000	150.00 Weekly	222.00	111.50	296.00	148.50

*Amount poyable depends upon the nature of the loss as set forth in the policy.

Administered by

J. L. CRUMPTON, Stote Mgr.

Professional Group Disobility Division
Box 147, Durham, N. C.

J. Slade Crumptan, Field Representative

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Originator and pioneer in professional group disability plans.

ministration of the drug. In some cases the dosage was reduced, usually with disappearance of the drowsiness. The compound was discontinued in 4 patients who complained of "nervousness" and in 3 patients who complained of lethargy.

One 26 year old patient with generalized atopic dermatitis (disseminated neurodermatitis) attempted suicide by ingestion of thirty 4-mg. tablets of methdilazine hydrochloride following a heated argument with her husband. She was taken to a hospital where her stomach was lavaged after approximately one hour. No ill effects were reported by the patient, who commented that she "didn't even feel sleepy."

Summary and Conclusions

1. A series of 373 patients with various pruritic dermatoses have been treated with a new orally administered antihistaminic drug, methdilazine hydrochloride.

2. Methdilazine hydrochloride has been significantly effective in controlling itching in 301 cases (80.6 per cent).

3. No serious side effects were observed, although minimal to moderate drowsiness was noted in 29 patients. This phenomenon usually promptly disappeared when the dosage of the drug was reduced. In other cases drowsiness, appearing initially, gradually subsided even though the compound was continued at the same dosage.

4. This preliminary report indicates that methdilazine hydrochloride is a promising antipruritic agent which merits further study

References

- Weikel, J. H., Jr. and Lish, P. M.: Some Important Aspects of the Pharmacology of Methdilazine, The Pharmacologist 1:64, 1959.
- Weikel, J. H., Jr., Wheeler, A. G., and Joiner, P. D.: Metabolic Fate and Toxicology of Methdilazine, Toxicology and Applied Pharmacology 2:68-82 (Jan.) 1960.
- Callaway, J. L. and Olansky, S.: Trimaprazine: An Adjuvant in the Management of Itching Dermatoses, North Carolina M. J. 18:320-321 (July) 1957.

Our Personal Challenge: The Key To Tomorrow

JOHN R. KERNODLE, M.D.*
BURLINGTON

The single word "aging" has created explosive vibrations across America today. Each of us has his own interpretations, fears and anxieties, and his own ideas as to how he or she will meet this challenge.

As human beings, we can appreciate our advantages and opportunities only by experiences. Whatever your age (and in this audience many age groups are represented), ask yourself this question: "What do I want for my older years?" If we could list the answers on a blackboard, I dare say the collective "wants" would fall into three or four categories and would be the same "wants" as you have today in your present age group.

1. Security. Fulfillment of basic needs—food, clothing, shelter, health, medical services, and an income sufficient to maintain self-reliance and independence.

2. Continuation of ego satisfactions. Self-expression, authority, respect, dignity, integrity; independence of thought, action,

Read before the Regional Conference on Aging, Atlanta, Georgia, March 7, 1960.

From the Kernodle Clinic, Inc., Burlington, North Carolina.

decision, and judgment; opportunity to develop talents, interests, and occupation.

3. Opportunity to contribute to and participate in—family, community, and society, as a useful personality.

You have heard it stated many times that the greatest fears of old age are loneliness, reclusion, and uselessness. Our personal challenge is to prove these fears false and to look ahead to years of "living" with new hope and optimism, and not to sit idly by and "live" in the past. There are new and wider horizons ahead for us all.

It is a personal challenge to me to join this group and to appear on the program. The topic assigned me is "Our Personal Challenge: The Key to Tomorrow." As we look ahead, certain questions come to mind.

- 1. How are we to accept a "realistic attitude" toward growing older? How are we to help others?
- 2. How educated are we to recognize the opportunities of older age?
- .3. How mature are we in our appreciation and understanding of the chal-

lenges and responsibilities of our added years?

4. What can we as individuals do now in preparing for our later years?

5. What is the true meaning of age? What new opportunities does it offer? What limitations can we expect? How can we judge between the two?

A Realistic Attitude Toward Aging

In answer to the first question—developing a realistic attitude towards aging—we first have to recognize the fact that aging begins with birth, not at 65 years or any other chronologic stage. We must recognize a transition in values. With age we gain in ability, talents, authority, and judgment. These characteristics do not suddenly disappear with a given number of years. It takes a life-time of "living" to build, learn, and develop these personality traits.

Modern America places the emphasis on youth, young families and youthful ambitions. It is a race for material gains which are necessary to maintain our standard of living. Our youthful and middle-age years must be spent in building the security we all strive towards for our retirement years. We look constantly to the future, directing all our energies towards this goal, and we must train our children to anticipate a much longer life span than has ever been necessary for any other population group.

America is a young nation—and as a young nation, we have stressed the importance of "vim, vigor, and vitality" with all the pressures at hand to expand. We have set standards by production quotas, efficient labor-saving devices, and pyramiding consumer goods and services. These standards are good, and we do not wish to curtail this enthusiasm. Our demands will continue as our population growth and increasing life span create additional pressures to meet the needs of a growing nation. Yet in this hurry and bustle, let us not lose sight of those who, by age and experience, can give us the benefit of their trials and errors, mature judgment, and evaluation of the "real" purposes for living. We are still individuals, living in groups, having our own basic needs and wants to satisfy entirely by our own accomplishments and behavior.

As we look ahead to years of reduced activity, forced or voluntary, we must

build up inner strengths and security for continued useful and happy living.

We can learn much from our senior citizens-and from countries where age has not lost its dignity, but is regarded with respect and love. In many countries the "head" of the household, business, or industrial organization is the eldest. Age has a different perspective-one of wisdom, integrity, and sound counsel. Too often in America, we have pushed aside those possessing these attributes to make way for more active, alert, and energetic young leaders. Let us recognize our loss, take another look at our values, and make the best use of these experienced people. Brainpower does not develop over night, nor does it suddenly stop or deteriorate at a given

Chronological Age Versus Realistic Age

We have suddenly awakened to the fact that we have now, and will continue to have, more and more people living beyond 65 years of age. Our forced retirement laws and policies are based on a misconception of the limitations of age. We spend years developing our skills; suddenly we have a birthday and all is lost. This is a mistake, one that must be recognized and corrected. When a man or woman has had it hammered into him all his life that at 65 he will be old and useless, it is difficult for him to believe otherwise . This is especially true if he is simultaneously confronted with occasional aches and pains or by restrictions in his physical activities. If the younger members of his family or his working associates act as if they believe the falsehood, it is doubly hard for him to resist the temptation to just quit.

That intangible quality called the "will to live" is not something the physician can prescribe in convenient doses obtainable from the nearest pharmacy. Yet people who have it can continue to meet new challenges and make the necessary adjustments. It is not so much that age or disease has defeated the patient. It is the fact that he has prematurely surrendered. A lonely man, rejected by family and friends too busy to bother, may quite understandably feel that he is simply serving out an interminable life sentence. Elbowed aside by a society that places the accent on youth, a society that is prone to measure human value in terms of productivity, a society that is always in a hurry, such a man is apt to feel that his life lacks either purpose or importance.

This is the man who is ready to throw in the sponge—regardless of age. Older people, like young ones, need something to live for.

The best way to give it to them is to show them that society does care; that society values their wisdom, experience, and capability; that society is anxious to use their talents and skills and above all, that society *needs* them.

There is one more job which society must do: it must encourage our older citizens in their desire to be useful. Few who reach retirement age have lived useless lives. Most have contributed, according to their individual capacities, to their communities.

When we look at the 60 year old man of today, we must acknowledge two things: (1) that he is healthier and more capable than was his counterpart of 1900; (2) that the 60 year old man who will follow him in 1999, the youngster who this year will cast his first vote, will have even better health, greater capacity, and greater life expectancy.

"Experts in the field of aging know that many people, as they grow older, underestimate their capacities. But if they accept the challenge of circumstances, they almost always discover to their astonishment that they can do more and endure more than they had dreamed. Physicians today believe that in this sense most people are younger than they think—and unfortunately that in thinking themselves older than they are (using a predetermined chronological age-limit), they may actually be hastening their own decline."*

Our personal challenge is "to explore the opportunities for positive health and life fulfillment for all age levels." Life fulfillment, meaningful living, and useful living cannot be considered separately from health. Purpose in life and the opportunity to express it are fundamental to good health. It is for this reason that the medical profession, primarily interested in health, is holding conferences such as this throughout the nation. It should be noted, too, that as a profession, we are concerned with more than the absence of disease—

namely, optimum health, positive health, and maximum enjoyment of each person's potential—physical, mental, and spiritual.

The achievement of optimum health in later years is a major individual challenge to each of us, regardless of our age. At the same time we can follow a health maintenance program which fully recognizes the values of such special health-oriented concepts as periodic health appraisals, sound nutrition, and adequate exercise.

You and I have a responsibility to reevaluate carefully the education of our young people regarding aging. This reappraisal should be to both the informal and formal education of children in grade school, high school, and college.

In order for the young person of today to comprehend that he has the distinct possibility of living much beyond 70 years—to 90, 100, or 110, he must begin now to reevaluate his attitude toward life, its length, and his capabilities within these years.

Those of us in the middle-age group should be seriously challenged by the fact that we have many years before us. Those years can be fruitful and satisfying for most of us if we will but recognize the prospect and prepare for it. Now is the time to initiate a health maintenance program to pace ourselves, like the miler, for the long run ahead. We should recognize that when we reach 65 we are not old, and that we can do much to maintain and improve our health while we continue to mature.

Leaders, at any age, we must recognize a personal responsibility to help others achieve a realistic attitude towards aging. The first step is to reeducate ourselves as individuals. The second step is to reeducate others. Both steps are mandatory if the new era of aging is to be a golden one.

The new revolution of aging is qualitative as well as quantitative. It is a by-product of a healthier nation. With an increased life span and better health, we must avoid making these added years merely a time to remember the past. Although medical science has helped lengthen the lives of millions, society must bear the responsibility of making those years a blessing instead of an empty reprieve.

To prolonge the "challenge" of living, sound community and family practices can

^{*}Quoted from Today's Health, June, 1959.

contribute. But in the final analysis, the response that each of us makes to life depends on ourselves.

Someone once said that there is no shortcut to old age because it is the work of a lifetime. There's no denying this truth. It is equally true that society must help prepare the individual through education for retirement and old age. This, too, is the work of a lifetime. Opportunities must be provided the older person to continue his growth, his learning, his interest, and his productivity. Families must re-assess their responsibilties toward their older members, neither overcoddling nor rejecting them, but giving them places in family councils and activities compatible with their capabilities.

As physicians we are trained and experienced in diagnosing the causes of physical complaints, diseases, and infirmities, but we have also learned to recognize social and emotional maladies that frequently produce physical ills. The therapy must be performed by the patient's family, friends, church, and community—that complex group we call society.

In meeting our responsibilities, we should miss no opportunity to contribute to the formation of a new attitude on aging in all our social patterns; an attitude which is essential to positive health and meaningful living among older persons.

Summary

Our personal challenge is to see more clearly the full implications of the revolution in aging now taking place. In order to realize its benefits we must combat misconceptions about aging with a new understanding which recognizes the advances made in the past 25 years and which foresees the possibilities of developments in the next 25 years.

The revolution in aging is a dynamic, continuing process. Medical progress has not stopped. Improvements in general education, standards of living, mental health, labor saving devices, knowledge of nutrition, and all the other elements which have already helped to lengthen life and increase the capacity of individuals for effective living likewise may be expected to increase in years ahead.

In a democracy, we each *earn* our respective rights. This we do by performing to the best of our abilities and capacities, and once recognizing the opportunities for

growth and development, by assuming the responsibility of fulfilling these needs, wants, and rights.

When faced with the need for re-adjustments in family relationships, in employment, in community relationships, and in self-appraisal, we renew our will to perform, participate, and contribute.

We must, as a society, educate ourselves, our youth, and our older people to assume this new attitude towards security, expression of maintenance of ego, and to look ahead for new avenues through which to contribute and participate.

Society must provide extended opportunities and benefits of regular "pay-days" for our older citizens.

The individual must be educated throughout his formative years to develop new talents, abilities, and capacities so that he is able to adjust to new pay-day activities and challenges.

Today we are discussing our concern for our aging population, whereas in other parts of the world the major concern is one of overpopulation and the rapid increase in birth rates.

As a physician and as a citizen in my community, I have a deep concern and a feeling of responsibility to do what I can to help assure the babies born today a more useful, more enriched, as well as a much longer life span.

"The will to live to the fullest of our capacity—to die on our feet—and not bent on our knees"—is our personal challenge and the key for tomorrow.

In closing I would like to quote from an unknown author as follows: "Youth is not a time of life. It is a state of mind. It is a temper of the will—a quality of the imagination—a vigor of the emotions. Nobody grows old by merely living a number of years. People grow old only by deserting their ideals.

Years wrinkle the skin, but to give up enthusiasm wrinkles the soul. Worry, doubt, self-distrust, fear and despair—these are the long, long years that bow the heart and turn the greening spirit back to dust. Whether sixty or sixteen, there is in every human being's heart the lure of wonder, the undaunted challenge of events, the unfailing child-like appetite for what next, and the joy of the game of living.

We are as young as our self-confidence, as old as our fear; as young as our desire, as old as our despair.

Life for the Added Years

MRS. OLIVER ROWE
CHARLOTTE

My approach to this challenge will be that of a wife, a mother, and a grand-mother. I am intensely interested in this subject of the "Added Years" and its relation to the family.

What is Old Age? An unknown author

expresses my sentiments:

How do I know my youth has been spent? Because my get up and go has got up and went.

But I really don't mind, when I reflect with a

On all the places that it has been.

Aging is a process of changes. Those who resist and resent it grow older faster, while those who are flexible and accept it grow old gracefully. But we all get there, one way or another, if we are lucky.

Most families look forward with some apprehension to the day when the breadwinner retires from active business. Their concern might be summed up under two headings:

 They do not want to give up the influence they have enjoyed in the community.

They do not want to lose their economic security.

The level of health and capability at every age has been raised over that of previous generations. This fact is bound to bring about a raise in the retirement age, throughout industry. Continued employment in one's profession, business, or trade will automatically solve a large part of the problems brought on by aging.

There are no *new* problems. We have had all the same problems with the aged since time began. The only new thing is that we are going to have a higher percentage of aged people in our population than ever before. Maybe we need not worry about what we should do for the aged, but rather contemplate what this overwhelming number of aged in our population might do to us.

Adjustments Within the Family

Our concern today is oriented toward the family and the individual.

As it relates to the family, aging is a process of adjustment, the responsibility

for which falls alike on all members of the family group. Not only do we have the challenge of dealing with different generations living together, but, as the trend is to have more children on the one hand, and to live longer on the other, Youth and Old Age are living together for a longer period of time.

As families, we must recognize this as a new concept. We must put away our outmoded ideas of "Too old at 40", and "No job after 65." By 1976, which will be the Two Hundredth anniversary of the Declaration of Independence, this nation will have 22 million people over 65 years of age. We have 15 million of them today, and they are increasing at the rate of 1,000 per day, according to Dr. Elmer Hess.

In spite of this great population expansion of both young and old, and in spite of the automation of industry, a shortage of workers is predicted in the future. This is because the technological advances are opening up new industries, and also because these additional people will bring with them higher standards of living, demanding new and wider consumption of goods and services. Industry will have an increasing need for the skills and experience of the future citizen past 65.

Along with this new concept, I would like to see a new emphasis put on the family unit. The family is the heart of our nation; it promotes responsibility and independence—which makes for good citizenship. It is this country's greatest source of strength.

If you will pardon a personal reference, I can speak from experience on this subject. I have lived in a household of three generations for 32 years. There were 13 of us in the same house at one time, making up four family units. It has been a wonderful experience. We think of ourselves as a clan. We have a deep sense of family loyalty which is a joy and a tower of strength. We have a love of belonging that few families living separately ever achieve.

There is no secret formula for this "togetherness." It is simply that we love and respect each other in spite of our differences. The advantages derived are greater than the disadvantages. We realize that each generation has a contribution to make to the other, and we are grateful for the privilege of sharing it. There has never been, nor will there ever be, a problem of the aged in our family.

Adjustments in Society

Someone has said: "The firmest foundation for old age security lies in the mutual relationships of understanding between youth and its elders." Women in their role as homemakers can bring about this relationship. Now, what can women, through their organizations, do to meet the challenge created by a revolution in aging? How can we prepare ourselves, our communities, our institutions, and our families for long, useful lives?

We agree, I think, that the "added years" must be fruitful if they are to be happy ones, or if they are to be used fully as a national resource. We can depend on industry, I think, to make it possible for people to continue longer in their chosen profession, business or trade.

Care of the indigent

Americans are by nature independent and thrifty. Most of the aged who cannot work will have provided themselves with financial security through their own savings, investments, pension plans, and insurance. The indigent should be cared for by local charities and public welfare agencies. These people should not, through any new scheme, become wards of the federal government.

We, as women and as thinking individuals, know that any federal government plan would be compulsory, inflexible, financially back-breaking for the taxpayer, and inadequate because of political red tape. For the federal government to make a political football out of caring for the aged, social security taxes would be raised, in some cases, higher than a person's income tax. Such a situation would seriously affect the country economically, as well as reduce our ability to deal with the problem in an effective, humanitarian way.

We should reject as unsound any approach to solving this problem through a compulsory hospital and medical insurance

law administered as part of the social security system. The White House Conference on Aging, building on the sound structure of such state and regional meetings as this one, can be urged to let the ingenuity of American private enterprise solve the insurance problem. We can also urge the Conference to establish goals for private, local, and state action in the field of geriatrics.

Participation in the community

Getting back to what women's organizations can do: We are concerned with providing a community environment which will give older people an opportunity to participate in activities of interest to them, and thereby attain a fuller life. We must not make the mistake of assuming that they are helpless in this area. In fact, when the news leaked out that life expectancy was going to push the 100 year mark, many of our old people got up out of their rocking chairs and threw their canes away! They began thinking about adding life to their years, as well as adding years to their life. They have formed their own Grandmothers' and Great-grandmothers' clubs, Best Years clubs, Golden Years clubs, book clubs, sewing clubs-and I heard the other day of a "Poem" club. They are having a great time!

These are the "self-starters", the exceptional ones, who are able to organize their own groups on the basis of interest and skill. But the great majority need outside help and stimulus, and that is where we, through our women's organizations, may be able to open new horizons for them and ourselves. Because of the limited time, I have chosen only a few examples. Let's look first to the area of political activity. Political activity

Do you know that studies of voting behavior show that the percentage of registered voters and the voting record of the 50 to 75 year age group, is higher than that of any other segment of our voting population? The Gallup Poll estimates that 1 out of every 4 potential voters this year will be over 60 years old. Senior political clubs are now being organized all over the country. They are easy to organize in areas where there are many retired people —people who have the time, the knowledge, the experience, and the executive ability to carry through their programs.

This activity will fulfill their need to be busy, useful and wanted. I know of no greater service you could render your community and its senior citizens in this election year than to encourage the use of this source of manpower in your own political organizations. I might add, I know of no area which needs this experienced help more.

Our elder citizens should be encouraged to use their voting power as a block of strength to combat inflation; it is to their interest and ours to contribute to a sound fiscal policy. In this way these 15 million Americans, living on fixed incomes and pensions, can help themselves and the nation at the same time.

Special organizations

Women's business organizations could set up counseling and training courses for mature women, and inform them of suitable jobs in their community. The club might even operate a part-time employment service for the "over 60" group.

The Junior League is interested in social problems. A voluntary service to people in homes for the aged would be in keeping with its program.

The Y.W.C.A. is keenly aware of its responsibility to meet the needs and interests of all groups in a community. Its year-round program is flexible and varied, but the present emphasis is on the teen-aged and the young married groups. In the interest of older women, consideration might be given to an "Arm Chair Travel" class. Or perhaps older women could be enlisted to help with the programs or to attend nursery children while young mothers are in classes.

The Federation of Women's Clubs work in many areas—educational, civic, welfare, and social—all of which offer opportunities for older women.

The American Association of University Women has a study group on almost every conceivable subject. You name it; they have it. This might be a good organization to sponsor, in cooperation with the local library, a library service to serve older people who are shut in. It might organize

weekly reading and discussion groups of older women.

Medical auxiliaries might be the logical organizations to spearhead movements to raise the standards of nursing homes to an acceptable level, and to seek acceptance of these homes as a resource of safe and comfortable living for our aged invalids.

Church related organizations provide excellent opportunities for developing programs which will use the combined assets of the younger and the older members. Both groups working together can combine new ideas with experience, and they make quite a team!

Our church has an active member, 75 years young, who has organized all the "oldsters" in the surrounding community into a "Best Years Club." She has enlisted the cooperation of the young women, who take turns providing transportation, serving as hostesses, and arranging programs and trips. Her help in organizing clubs in other communities has received national publicity. She says the club helps older people who have too much family as well as those who have no family at all.

I have, for many years, belonged to a Sunday school class of members from 20 to 30 years my senior. Our teacher is a retired school teacher and a brilliant Bible scholar. She lives at the Methodist Home, some seven miles from our church. The three younger members of the class take turns bringing her and any other senior members who need transportation to the various class and church meetings. I joined the class when I was much younger, because I thought the "old ladies" needed me. But the truth is, I have received much more from my association with them than I have even given.

Conclusion

If our senior citizens are to have the expanding opportunities for a full and meaningful life, we must take the facts, ideas and plans presented here back home to our organizations and communities and put them into action.

Someone has said, "Action without knowledge is foolish, but knowledge without action is futile.

North Carolina Medical Journal

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MAY, 1960

DR. DERYL HART, PRESIDENT OF DUKE

Those who knew him well were not surprised to learn that Dr. Deryl Hart had been selected to succeed Dr. Hollis Edens as President of Duke University. Dr. Hart has headed the Department of Surgery of Duke School of Medicine from its beginning and was one of the founding fathers of the Private Diagnostic Clinic.

At the twenty-fifth anniversary of his professorship in 1955, his former residents and members of his department presented his portrait to Duke University and a silver bowl to him. Appropriate addresses were given by Dean W. C. Davison and Dr. Clarence Gardner, who was his first resident.

In his address, Dr. Gardner summed up well the qualities which make Dr. Hart well fitted for the great task ahead of him. He said that the silver bowl presented by his former residents contained their appreciation of his superb surgical judgement and technical skill, or his imperturbability and fairness in managing his group, of his unfailing gentlemanliness in all situations, and, above all, of his absolute integrity. Dr. Gardner said, "Everyone of us here at all times has been secure in the knowledge that once your word was spoken it would not be changed. This unfailing honesty, this universal fairness, this absolute integrity, above all else, has cemented us together."

This JOURNAL extends its congratulations to Dr. Hart and also to Duke University for having available one so capable of directing its destiny during the trying period ahead.

* * *

IMMUNE MILK FOR ARTHRITIS

The hope that springs eternal in the human breast has led many arthritic patients to become interested in the so-called "immune milk" which has been widely advertised as a cure for arthritis. The following authorative statement from the Arthritis and Rheumatism Foundation will provide an answer for the physicians who has asked about it.

"Commenting on claims made for the 'milk' in recent major magazine articles, Dr. Ronald W. Lamont-Havers, medical director, explained that 'scientifically controlled studies of the product show it has absolutely no effect on the disease.'

"The 'immune milk' developed by Professor William E. Peterson, a specialist in dairy husbandry, alledgedly gets its immunity to rheumatoid arthritis from antibodies produced in the udders of cows injected with streptococcus and staphylococcus vaccines. The victim of the disease, according to the theory, then gets his 'immunity' or 'cure' by drinking a quart of the 'milk' a day. Sold at \$1.10 a quart, it must be taken every day for a 'prolonged period to terminate the disease entirely,' claim the producers.

"Dr. Lamont Havers pointed out that there is no evidence that streptococci or any other living agent directly causes rheumatoid arthritis, and that treating patients by injecting such vaccines was tried and discarded by physicians more than 20 years ago. Even if these antibodies were beneficial to sufferers, he explained, careful studies have shown that antibodies in milk are infrequently absorbed by humans.

"The Foundation's medical director went on to emphasize that 'widespread circulation of such inadequately documented claims not only raises false hopes among the nation's arthritis victims, but produces public pressure to devote valuable research time to testing theories which show no promise of being effective."

Some authority, probably Dr. Philip Hench—has spoken of "the inevitable 70 per cent of improvement" that follows every new remedy presented with enthusiasm. This principle would account for the apparent good results of the "immune

milk."

AMERICAN ASSOCIATION OF DOCTOR'S NURSES

Since it is quite possible that some doctor's nurses and doctor's aides may be misled by an outfit calling itself the American Association of Doctor's Nurses, a statement from American Medical Association head-quarters to editors of state and county medical journal is printed in part:

"An organization called the American Association of Doctor's Nurses recently issued a news release stating that the American Medical Association will loan a part of its large collection of exhibits to this group's convention in Miami, Florida, June 23 to 26, 1960.

"This is an incorrect statement, The American Medical Association has not

loaned any exhibits to this group.

"Originally known as the American Registry of Doctors' Nurses, this organization, which mailed its promotional materials from Marianna, Florida, was said to be in violation of the Nurses Practices Act in Florida in 1958 by the Attorney General in that state.

"The Group moved to Washington, D. C. Last summer the Federal Trade Commission charged this group with misrepresenting itself as a nonprofit organization and with giving customers the means to misrepresent themselves as registered graduate or licensed nurses. The organization changed its name to the American Association of Doctors' Nurses and in a news release issued some months ago stated that

"The American Association of Doctors' Nurses... has assumed the membership of the old American Registry of Doctors' Nurses.'"

It is hard to understand how the new name and location can enable the promoters of this organization to continue operating with impunity. Surely the Federal Trade Commission will soon learn that the new name and location does not make the odor of the outfit more pleasing. Until this happens, however, every doctor should be on guard against giving unwitting aid to this racket.

BLUE SHIELD AND THE LONGER VIEW

Like a somewhat wayward child, Blue Shield often plays the role of favorite whipping boy for the doctors who created it. Wherever several physicians are gathered together—in staff room, committee meeting or on the second tee—someone is certain to take out after the local Blue Shield plan.

Some Blue Shield administrators confess to a wry satisfaction in all this—recognizing that a parent is always fussier with his own offspring than with a child for whom

he has no emotional affinity.

Blue Shield is a vast community umbrella designed to ward off the rain of medical adversity which falleth alike upon the just and the unjust. It serves the need of the average man as best it may, but it sometimes falls a little short of the special needs or wishes of the individual patient and his doctor.

In these parlous times, when the Forand philosophy seems to have so thoroughly infected the politicians of both parties, American medicine has reasons more apparent than ever before to honor those medical pioneers who built Blue Shield, and to support the civic and professional leaders who today are working so hard to make Blue Shield an ever more effective instrument.

None can doubt that without the reality of a strong and growing Blue Shield movement during the 1950's, America would long since have had universal compulsory health insurance. And few today would dispute the proposition that if American medicine escapes the thralldom of state medicine during the 60's, it will have the voluntary prepayment movement — chiefly Blue Shield—to thank for its good fortune.

Let's all keep a closer eye on Blue Shield—not merely to discern the motes in its eye—but to encourage it to do the best job it can do for us and for the American people.

CANCER, COMMON SENSE, AND BUREAUCRACY*

Section 409 of the Federal Food, Drug and Cosmetic Act got a new page in September, 1958. It had the following new paragraph:

Provided: That no additive shall be deemed to be safe if it is found to induce cancer when ingested by man or animal, or (italics added) if it is found, after tests which are appropriate for the evaluation of safety of food additives, to induce cancer in man or animal.

Note the *or*. It means that either of these circumstances is enough to ban a food additive. "Appropriate tests" are not necessarily to be done.

This is the famous—the notorious, by now—"Delaney cancer clause." We have Representative Francis Delaney of Brooklyn to thank for it. The argument for it is as clear and simple as the argument against fluoridation. It goes like this: carcinogens can cause cancer; no one wants foods to cause cancer; therefore we don't allow carcinogens in foods. The fact that one might have to eat half a ton of the food daily for six months to get the carcinogenic effect is blandly ignored.

Thus we find the Federal Government making a public spectacle of itself by banning crops of cranberries because they contain traces of a weed killer which can cause cancer in rats. Ignored, by law, is the fact that this material is not known to be carcinogenic for humans in any quantity, and is surely not carcinogenic for anyone, rats or humans, in the amounts with which the user of cranberries on his Thanksgiving turkey is concerned.

In an ascending spiral of foolishness, we next find the Food and Drug Administration forbidding the sale of poultry caponized with stilbestrol. The fact that stilbestrol has been freely prescribed for many years in far larger amounts without being found to have caused a single case of cancer is just ignored. "Appropriate tests," you see, are not needed.

Next comes lipstick, containing a dye which has been found to produce cancer in some rats, if ingested. One could work out the approximate quantity required to cause cancer, and warn the public against eating more than two, or four, or six lipsticks a day for longer than two, or four, or six weeks, as the case might be. It seems abundantly clear that the trace amounts of lipstick dye ingested by users would be of a far lower order of magnitude than the carcinogenic amounts—if, indeed, the dyes are carcinogenic for humans at all. Carcinogens are curiously specific substances, sometimes.

So far, only food additives have been banned. Fowler's solution, cigarette smoke, sunlight, the charred surfaces of charcoal broiled steaks, and the recently identified carcinogen (for rats) isolated from egg yolk by Hradec at the Prague Oncologic Institute, are all still available for those of us who would live dangerously.

One wonders why the Department of Health, Education and Welfare would create these teapot tempests, and so harass cranberry growers, poultry raisers and cosmetic manufacturers. Could there be a political motive? Surely not; after all, the law is very clear, and they have no choice but to obey it.

The suggestion has been made that we might require manufacturers to prove their proposed additives are not carcinogenic. This specious suggestion seems to us, on inspection, absurd. How could it be done? How could one prove that the sodium benzoate in catsup in not carcinogenic? The only way to prove that something might happen is to prove that it has happened. There is no way to prove that it could not happen.

One can hope, however, that the future will bring a more sensible interpretation, if not a more sensible wording, of the law. The present wording and interpretation, in addition to making a lot of people unhappy and doing little good, seem calculated to discredit the F.D.A., and through it the Department of Health, Education and Welfare and even the Congress. A national authority is not immune to the fate which befell the boy who cried "Wolf!"

^{*}Reprinted from the Hawaiian Medical Journal May, 1960.

CORRESPONDENCE

COMPULSORY INSURANCE

To the Editor:

In my humble opinion the American Medical Association is making a big mistake in opposing the Forand bill and at the same time saying the present social security program is a good thing. The A.M.A. should be consistent and oppose both of them, and for the same reason: that they are compulsory. For the life of me I cannot understand how the U.S. Government can constitutionally tell an American worker that before he can take a job he has to have a social security number and that a certain percentage of his pay must go for insurance. Why a man has to buy insurance if he does not want to is beyond my understanding. After all, it is his money. This is an entirely different principle from income taxes or any other taxes. It is money the government is withholding from a worker at the present time to give back to him in the future as an annuity. Insurance is a great thing but why does it have to be compulsory?

The whole social security program seems unconstitutional to me and un-American in principle. Compulsory health insurance (the Forand bill) is certainly no worse in principle than the Old Age and Survivors Insurance (Social Security)—it is the same principle and merely an extension of it. I think it is regrettable the A.M.A. did not strongly oppose the social security program when it was first proposed years ago. If it had done so, it would not be inconsistent today in opposing the Forand bill.

James K. Hall, Jr. M.D. Richmond, Virginia

Committees and Organizations

PHYSICIAN CONSULTANTS FROM COUNTY MEDICAL SOCIETIES TO THE BLUE SHIELD COMMITTEE OF THE STATE MEDICAL SOCIETY

BLUE SHIELD CONSULTANTS*

Because North Carolina is a State covering a large geographical area with one hundred counties and thousands of small communities, it is difficult, if not impossible, for one nine-man committee to adequately represent all physicians and all segments of the population. Because the political climate dictates the fullest expansion of voluntary health insurance and because non-profit Blue Shield Plans are the only type of insurance controlled by the Medical Profession, it is essential that all active practicing physicians understand present problems and opportunities and have a direct voice in the operation of their Blue Shield Plan. Therefore, the Blue Shield Committee appointed by the State Medical Society shall appoint one or more physicians in each County Medical Society with the following RESPONSIBILITIES. AUTHORITY and PRIVILEGES:

1. The County Medical Society Blue Shield Consultant shall be a physician engaged in the active practice of medicine who is a participating physician in the Blue Shield Plan. He shall be a recognized leader in the professional and civic life of the community.

2. The Blue Shield Consultant will receive from the Blue Shield Committee and its Secretary all up-to-date information concerning Blue Shield developments on both a State and National basis, including Committee Minutes.

 The Consultant will endeavor to arrange at least one annual meeting of the County Medical Society devoted to a discussion of Blue Shield.

4. The Consultant will receive any grievances or complaints and refer them to the Blue Shield Committee with his recommendation. The Consultant will have the privilege of attending meetings of the Blue Shield Committee by prior arrangement with the Chairman for consideration of any grievances or suggestions arising within the county.

*Unamiously approved by the entire Committee at its meeting of March 24, 1960.

- 5. The Blue Shield Committee when considering individual claims for evaluation will have the privilege of referring a claim to the Consultant for recommendation and a determination as to customary charges and practice within the county.
- The Consultant will be supplied with any pertinent data concerning participation, enrollment, and loss ratios within his county.
- 7. When the Blue Shield Committee believes that changes in the Plan may be desirable, the Consultant will explain the proposed change to his County Medical Society, determine the reaction of County Medical Society members, and relate the information to the Chairman.
- 8. The Blue Shield Committe shall have at least one annual meeting to which all Consultant will be invited.
- Blue Shield Committee members necessarily represent the entire Medical Society membership and all citizens. Consultants are concerned with a limited area. Therefore, a Consultant may be appointed even in those counties currently represented by a Committee member.
- Two or more Consultants may be appointed from the same county when a county has two or more sizable population centers served by hospitals in different geographic areas.

For the Committee Jacob H. Shuford, M.D., Chairman

Medical Teaching Films Available

A new medical teaching film program—to be conducted on a regular, continuing basis—has been announced by Smith Kline & French Laboratories.

The forthcoming film, expected to be released in April, will illustrate the essential principles and techniques involved in the resuscitation of newborn infants. Two earlier motion pictures, both of which have been widely acclaimed by medical andiences since their release, are "Human Gastric Function" and "Recognition and Management of Respiratory Acidosis."

As with these earlier films, Borland said, all of the series will be available to medical groups without charge. The 16 mm. motion pictures may be obtained on loan through SK&F professional service representatives or directly by contacting the Smith Kline & French Medical Film Center at 1500 Spring Garden Street, Philadelphia 1, Pa.

BULLETIN BOARD

COMING MEETINGS

North Carolina Hospital Association Annual Meeting — Morehead Biltmore Hotel, Morehead City, June 6-8.

Scaboard Medical Association Annual Meeting—Carolinian Hotel, Nags Head, June 17-19.

North Carolina Community Health Conference
—Sir Walter Hotel, Raleigh, June 29.

Duke University Medical Postgraduate Conrse— Morehead Biltmore Hotel, Morehead City, July 18-23

Sonthern Obstetric and Gynecologic Seminar—Grove Park Inn, Asheville, July 28-August 3.

American Medical Association 1960 Annual Meeting—Miami Beach, Florida, June 13-18.

Western Reserve University Seventh Institute on Science in Law Enforcement—Cleveland, Ohio, June 20-25.

A.M.A. Industrial Health Conference — Hotel Charlotte, Charlotte, October 10-12.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of April, 1960:

William Andrew Whitson, M.D., Box 326, Mars Hill; Oscar Leo Redwine, M.D., Box 66, Kenansville; Ralph W. Bland, M.D., 403 N. Herman, Goldsboro; Carroll Clifton Shoemaker, M.D., Scott Clinic, Rt. #2, Burlington; James Donald Vaughn, M.D., Waynesville; William Edward Bellamy, Jr., M.D., State Hospital, Raleigh; Robert Alexander Moore, Jr., M.D., 2415 Warwick Rd., Winston-Salem; Robert Allen Melton, M.D., Pirate's Cove, Rt. 3, Box 92, Wilmington; C. A. Kimel, M.D., 4132 Snyder Drive, Winston-Salem; Neel H. Bronnenberg, M.D., 420 N. Center St., Hickory; William B. Hall, M.D., 327 Ray Avenue, Fayetteville; Robert Gale Cushman, M.D., 11 13th Avenue, N. E., Hickory; Henry Pate Singletary, M.D., 3438 Wilshire Blvd., Wilmington, Alpheus McCullen Covington, M.D., 303 Leak St., Rockingham; George Dennett Lumb, M.D., 1323 Hawthorne Rd., Wilmington; Edwin Lee Pierce, M.D., Medical Arts Bldg., Raleigh.

SEABOARD MEDICAL ASSOCIATION

The sixty-fifth annual meeting of the Seaboard Medical Association of North Carolina and Virginia will be held at the Carolinian Hotel, Nags Head, North Carolina, June 17, 18, and 19. Speakers and subjects listed in the preliminary program include the following:

The Timing and Selection of Surgical Procedures in the Management of Pancreatitis—Colin G. Thomas, Jr., University of North Carolina. Essentials in Treatment of Several Common Diseases of the Skin—Donald M. Pillsbury, M.D., University of Pennsylvania.

Recognition and Management of Anemia—Byrd S. Leavell, M.D., University of Virginia

Some Aspects in the Treatment of Cancer— John R. Heller, M.D., Director of National Cancer Institute

Collateral Circulation in Occlusive Cerebral Vascular Disease—Bernard J. Alpers, M.D., Jefferson Medical College

Does Alcohol Damage the Liver When Taken Before, After, or Instead of Meals—John T. Sessions, M. D. University of North Carolina

The Menopausal Era—Franklin L. Payne, M.D. Modern Management of Diabetes—Garfield G. Duncan, M.D., University of Pennsylvania

The Care and Feeding of Injured Athletes and Coaches—Thomas B. Quigley, M.D., Harvard University

Four breakfast roundtable discussions, limited to 12 persons each, will be held Saturday morning June 18. Subjects and moderators are

- Fever of Unknown Origin—Ivan L. Bennett, Johns Hopkins University; Donald T. Faulkner, M.D.
- 2. What to do About the Enlarged Prostate—C. D. Creevy, M.D., University of Minnesota
- 3. Pregnancy and Diabetes—Garfield G. Duncan, M.D.; Edwin Monroe, M.D.
- 4. Problems of the Newborn-Waldo E. Nelson, M.D.; David Tayloe, M.D.

Also on Saturday morning a panel discussion on Infectious Disease will be conducted by the following: Drs. Waldo E. Nelson, Temple University; Dr. C. D. Creevy, and Dr. Ivan L. Bennett.

Reservations should be made with the manager of the Carolinian Hotel for rooms at the hotel or one of the nearby Seaboard Medical Association approved motels.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

On July 1 for the first time in 33 years—the Duke University Medical School will have a new dean.

Duke University President A. Hollis Edens has announced the appointment of noted neurosurgeon Dr. Barnes Woodhall, a 55 year old veteran of 23 years on the faculty at the Duke School of Medicine, to succeed the school's first dean, Dr. Wilburt C. Davison, who is retiring.

Actually, Dr. Davison will not officially retire from the University faculty until August 31, 1961, but is relinquishing the deanship on July 1 of this year in order to provide for a smooth transfer of administrative duties to his successor, Dr. Edens stated. Dr. Davison will serve during the 1960-1961 academic year as James B. Duke Professor of Pediatrics, a job which he has held for many years in addition to the deanship.

Widely known for his professional skill and his leadership in professional activities, Dr. Woodhall is a national consultant in neurosurgery to the Veterans Administration and is vice chairman of the Special Medical Advisory Group to the Administrator of the Veterans Administration. At the present time, he is serving as treasurer for the Second International Congress of Neurological Surgery to be held in this country next year. In addition, he is a member of the executive council of the World Federation of Neurosurgical Societies.

Co-editor and a contributor to a recently published two-volume History of Neurosurgery in World War II, he is a member of the Advisory Editorial Board on Medical History to the U. S. Army Surgeon General. His writings also include three monographs dealing with various aspects of neurosurgery and some 80 papers published in scientific journals.

Dr. Davison has received a host of honors during his long career. His most recent distinction came this week when he was named the third recipient of the Certificate of Meritorious Service given by the American Academy of General Practice for his contributions toward the advancement of the general practice of medicine and surgery.

During his three decades as dean; the Duke Medical School has produced more than 1,800 physicians and a host of workers in auxiliary fields of medicine. Growth of teaching, healing and research facilities and programs has been constant during his administration and today, the Duke Medical Center is in the midst of still further major expansion.

Dr. Thomas D. Kinney has been named professor and chairman of the pathology department at the Duke University Medical Center, Dr. Marcus E. Hobbs, dean of the University, announced recently.

The appointment is effective September 1. Dr. Kinney is currently a professor of pathology at the Western Reserve University Medical School, Cleveland, Ohio, and director of pathology at Cleveland Metropolitan General Hospital

He will succeed Dr. Wiley D. Forbus to the pathology department chairmanship. Dr. Forbus will continue to serve on the Medical Center faculty as a professor of pathology until his retirement in 1963 at the age of 69.

Dean W. C. Davison of the Duke Medical School said that Dr. Forbus requested the appointment of a new departmental chairman at this time in order to provide for continuity in adminstrative duties.

Bert R. Titus, director of Duke Hospital's Prosthetic and Orthopedic Appliance Center, has been elected president of the Southeastern Region of the American Orthotics (CQ) and Prosthetics Association.

The Association is composed of some 1,200 artificial limb and brace makers throughout the United States. Membership in the Southeastern Region numbers 200.

The annual national meeting of the American Orthotics and Prosthetics Association will be held in New York this fall. Next year's Southeastern Region meeting is scheduled for Asheville.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Some 50 persons representing 20 North Carolina blood banks met recently at the University of North Carolina School of Medicine to form the North Carolina Association of Blood Banks. The purpose of the new organization is the improvement of blood banks throughout the state and the better utilization of blood.

An interim board of directors for the new association has been elected. The board is composed of Dr. Bob Andrews, president, Southeastern General Hospital, Lumberton; Dr. Robert Langdell, secretary-treasurer, N. C. Memorial Hospital, Chapel Hill; Dr. Inez Elrod, Red Cross Piedmont Carolinas Regional Blood Center, Charlotte; Mrs. Wilhelmina Beesser, medical technologist, James Walker Memorial Hospital, Wilmington; Dr. Robert Prichard, Bowman Gray School of Medicine, Winston-Salem; and Edward Carr, medical technologist, Cabarrus Memorial Hospital, Concord.

The purposes of the association, as outlined in the articles of incorporation, are:

(a) To expand blood bank facilities to meet the needs for blood and its derivatives for every person in the State of North Carolina.

(b) To promote and foster the exchange of ideas and materials and information relating to blood banking and transfusion services.

(c) To foster and develop a clearing house or organization for the exchange of blood and/or blood credits within and without this state.

(d) To assist in the provision for, equipment for and operation of, blood banks, which, for the purpose of this organization are defined as medical facilities which are designed, equipped and staffed, to procure, draw, process, store and distribute whole blood or its derivatives without assumption of legal or financial responsibility.

Plans are now under way for a meeting in the fall in conjunction with technical workshop on blood banking methods.

A new blood research laboratory at the University of North Carolina has been named in memory of a Durham girl who died in 1956, a victim of acute leukemia. Trustees of the university have approved a proposal to name the new building for Miss Francis Owen, daughter of Mr. and Mrs. Fred C. Owen of 1220 Bivins St.

The financial help of the Hemo-Cardiac Foundation, Inc., founded by Mr. and Mrs. Owen in

1955, and the personal interest of the Owenses made possible the construction of the laboratory at this time.

The Foundation was set up for the purpose of raising money for medical research, particularly research concerning leukemia and heart disease. The Owens started the Foundation with a substantial contribution, and since that time Mr. Owens has devoted most of his time toward promoting the undertaking. His efforts have stirred the interest of a number of other people and have been rewarded with considerable success.

In addition to providing space for the care and treatment of experimental animals and laboratory facilities for basic blood studies, the new building will house a colony of some 40 hemophilic dogs. These are the only group of animals anywhere in the world suffering from this disease, and they have been of untold value in the blood research work at Chapel Hill.

Dr. Kenneth M. Brinkhous, professor and chairman of the Department of Pathology at the University of North Carolina School of Medicine, was elected secretary-treasurer of the American Society for Experimental Pathology at a recent meeting in Chicago. This society is one of the component societies of the Federation of American Societies for Experimental Biology.

Eight papers were delivered at the annual spring meeting of the Society of North Carolina Bacteriologists at the University of North Carolina School of Medicine recently.

The guest speaker at the dinner session at the Carolina Inn was Dr. Chester W. Emmons, chief of the Medical Mycology Section, National Institutes of Health, Bethesda, Maryland. His topic was "Environmental Habitats of Pathogenic Fungi."

Principal speakers were: Dr. John Carr, VA Hospital, Durham; Dr. David T. Smith, Duke University School of Medicine, Durham; Dr. Henry G. Cramblett, Bowman Gray School of Medicine, Winston-Salem; Drs. D. O. Morgan, J. G. Leece and G. Matrone, North Carolina State College, Raleigh; H. Stoffer and Dr. John H. Schwab, Dr. W. J. Cromartie, and J. J. Crawford, U.N.C. School of Medicine, Chapel Hill.

A conference of Thrombolytic Agents was held recently in Chicago under the auspices of the University of North Carolina School of Medicine.

The sponsor of the conference was the National Heart Institute of the U. S. Public Health Service.

Physicians participating in the conference from the U.N.C. School of Medicine included Dr. Kenneth M. Brinkhous, chairman of the conference, and Drs. John Ferguson, R. H. Wagner, Robert Zeppa, Harold Roberts, Dieter Geratz and S. G. Iatridis. Also attending was George W. Norwood, business manager of the U.N.C. Division of Health Affairs.

Philosophers and psychiatrists got together for scholarly talks at a "Symposium on Existentialism, Phenomenology and Psychiatry" held in Chapel Hill on April 16-17.

Guest speakers from New York, Washington, and Lexington, Kentucky joined North Carolina specialists in these fields on the two-day program.

The University of North Carolina Departments of Psychiatry and Philosophy were joint sponsors of the symposium.

Principal speakers for the two day symposium included Dr. Edith Weigert, director emeritus of the Washington Psychoanalytic Institute; Dr. Ernst Manasse of the Department of Philosophy, North Carolina College at Durham; Dr. Lucie Jessner and Dr. Milton Miller of the UNC Department of Psychiatry; and Dr. Maurice Natanson of the UNC Department of Philosophy.

Physical therapists from throughout North Carolina attended the annual spring meeting of the North Carolina Physical Therapy Association held in Chapel Hill on April 23. The activities consisted of a business meeting, demonstrations and exhibits, and lectures in three areas of practice.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

New faculty appointments and promotions, effective July 1, have been announced by Dean C. C. Carpenter.

Appointments are as follows: Dr. Charles Max Drummond, instructor in anesthesiology; Dr. Joseph E. Whitley, instructor in radiology; Dr. Margaret C. Conrad, research assistant in physiology; Dr. Chong Moo Lee, fellow in pathology; and Alvin F. Moreland, D. V. M., fellow in laboratory animal medicine.

Promotions are as follows: Dr. William H. Boyce to professor of urology; Dr. Richard L. Burt to professor of obstetrics and gynecolgy; Dr. R. Winston Roberts to professor of ophthalmology; Dr. John R. Ausband to associate professor of otolaryngology; Dr. Thomas B. Clarkson, Jr., to associate professor of experimental medicine; Dr. Charles M. Norfleet, Jr., to associate professor of urology; Dr. Richard C. Proctor to associate professor of psychiatry; Dr. Robert J. Strobos to associate professor of neurology; Dr. Henry L. Valk to associate professor of internal medicine; Dr. Frank H. Hulcher to assistant professor of biochemistry; Dr. Samuel H. Love to assistant professor of microbiology and immunology; Dr. Richard G. Weaver to assistant professor of ophthalmology; Dr. Charles E. Whitcher to assistant professor of clinical internal medicine; Dr. I. Gordon Early to instructor in clinical internal medicine; and Dr. Paul L. Garrison to instructor in clinical internal medicine.

Several members of the Bowman Gray faculty presented papers and exhibits at the 1960 meeting of the North Carolina State Medical Society in Raleigh, May 7-11. They were: Dr. John R. Ausband, Section of Otolaryngology; Dr. Joseph J. Cutri, Department of Psychiatry; Dr. John H. Felts, Department of Internal Medicine; Dr. Frank Forsyth, Section of Orthopaedics; Dr. Felda Hightower, Department of Surgery; Dr. I. Meschan, Department of Radiology; Dr. Charles M. Norfleet, Jr., Section of Urology; Dr. R. Winston Roberts, Section of Ophthalmology; Dr. Louis De S. Shaffner, Department of Surgery; Dr. Joseph E. Whitley and Mr. Richard Witcofski, both from the Department of Radiology.

The Bowman Gray School of Medicine Alumni Association sponsored a luncheon for their faculty, alumni, and wives in conjunction with the State Medical Society meeting in Raleigh on Wednesday, May 11. The event, held in the N. C. State College Union Ballroom, climaxed a very successful meeting.

Dr. D. E. Ward, Jr., of Lumberton, president of the Medical Alumni Association, presided at the luncheon. Approximately 150 alumni and faculty attended.

Two of the three named professorships in basic medical sciences established at Bowman Gray in March have been announced by Dean C. C. Carpenter. The recipients are Dr. Harold D. Green, the Gordon Gray Professorship of Physiology, and Dr. Norman M. Sulkin, the William Neal Reynolds Professorship of Anatomy. Dr. Green is chairman and professor of the Department of Physiology and Pharmacology. Dr. Sulkin is chairman and professor of the Department of Anatomy.

The former resident staff in urology, including 15 of the total 17 past and present residents, observed a day in honor of Dr. Fred K. Garvey on Friday, April 22. Dr. Garvey is director and professor of the Section on Urology. He has held the position as head of the section since the Bowman Gray School of Medicine moved to Winston-Salem in 1941.

During the morning scientific session, four research reports were presented to the group by the following members of the section: "Results of Ileal Conduits and Other Methods of Urinary Diversion," Dr. Garvey; "Results of Radical Prostatectomy," Dr. Charles M. Norfleet, Jr.; "Diagnostic Problems in Patients with Recurrent Urinary Calculi," Dr. Kenneth Carlson; and "Current Concepts of Structure and Composition of Urinary Calculi."

After lunch the group toured the N. C. Baptist Hospital, the para-medical schools and the Bowman Gray School of Medicine.

The day ended with a dinner at the Forsyth Country Club and a talk by Dr. J. P. Rousseau, former president of the North Carolina State Medical Society. Dr. Roussean's topic was "Changing Scene of Urologic Radiology."

Dr. James B. Wray, instructor in orthopaedic surgery, was recently elected to the American Association of Anatomists and the Orthopaedic Research Society.

Bowman Gray faculty members who recently presented scientific papers at the annual meeting of the North Carolina Academy of Sciences in Greensboro are as follows: Dr. Camillo Artom, professor of biochemistry: Dr. Thomas B. Clarkson, assistant professor of experimental medicine; Dr. Charles McCreight, assistant professor of anatomy; and Dr. Norman M. Sulkin, professor of anatomy.

INDUSTRIAL HEALTH CONGRESS

Representatives of industry, agriculture, medicine, and governmental agencies will gather in Charlotte, North Carolina, October 10-12, for the twentieth Congress on Industrial Health.

To be held at the Hotel Charlotte, the congress is sponsored by the American Medical Association's Council on Occupational Health and is held each year as a means of furthering the development and maintenance of high medical standards in industry and on the farm.

The congress programs are primarily directed toward the general practitioner, whom it is estimated, handles close to 90 per cent of all the occupational medical practice in the nation.

Among the topics to be discussed during the three-day conference are occupational health in agriculture, mental and emotional health in industry, problems in dermatitis in farm and industry, and occupational health problems in small employee groups.

Dr. Amos N. Johnson, president of the Medical Society of the State of North Carolina will be among the speakers.

Cooperating sponsors include the Medical Society of North Carolina, North Carolina Governor's Council on Occupation Health, Mecklenburg County Medical Society, and the Greater Charlotte Occupation Health Council.

EDGECOMBE-NASH MEDICAL SOCIETY

The monthly meeting of the Edgecombe-Nash Medical Society was held in Rocky Mount on April 13.

Dr. H. B. Grant, program chairman for April, presented as speaker Dr. Madison Spach of the Pediatrics Department of Duke Hospital, Duke University, whose topic was "Congential Heart Disease."

AMERICAN MEDICAL ASSOCIATION

The one hundred ninth annual meeting of the American Medical Association will be a forum presented by some of the nation's top scientists.

Approximately 2,000 physicians, all outstanding in their field, will participate in the scientific program of the meeting to be held in Miami Beach, June 13-17.

There will be two general scientific meetings in the Grand Ballroom of the Fontaineblean Hotel, and other lectures, symposiums, and panel discussions in the Fontaineblean, Eden Roc Hotel, and in the new, air-conditioned Miami Beach Exhibition Hall. Sessions on dermatology, being held jointly with the Society for Investigative Dermatology, will be in the di Lido Hotel.

About 290 exhibits will be on display in the Miami Beach Exhibition Hall, representing the most outstanding exhibits selected from 540 applications.

An outstanding program of motion pictures and television, which will be coordinated with the rest of the scientific program will be presented also in the Miami Beach Exhibition Hall.

SECOND ANNUAL PRE-CONVENTION SCHOOL HEALTH MEETING

The Second Annual Pre-Convention School Health Meeting, jointly sponsored by the American Medical Association and the American School Health Association, will be held on Sunday evening, June 12, in the Medallion Room of the Carillon Hotel in Miami Beach. This is the evening prior to the Annual Meeting of the American Medical Association.

An outstanding scientific panel on school health will be followed by a general discussion in which all those present may join. Since all professions concerned with the school health program will be represented, this an unusual opportunity to learn the attitudes of others with whom physicians work in protecting the health of children.

Those planning to attend the annual meeting of the American Medical Association in Miami Beach, should also attend the Pre-Convention Meeting on Sunday evening.

INTERNATIONAL MEDICAL ADVISORY BUREAU

The Council of the British Medical Association has established an International Medical Advisory Bureau with a view toward welcoming and providing a personal advisory service to medical practitioners visiting the United Kingdom. The Bureau is located at British Medical Association House, Tavistock Square, London, W.C. 1.

One of the main objects of the Bureau is to welcome the overseas medical visitor, who is cordially invited to visit the Bureau as soon as possible BULLETIN BOARD

after arrival and talk over with the Medical Director any points on which he may need advice or assistance.

Visitors are urged to inform the Bureau of his intended visit to the United Kingdom as much in advance of his arrival as possible. Advance information as to date of arrival, mode of travel, length of stay, main objects of visit and special needs for assistance will enable the Bureau to provide the best service. Those wishing to visit hospitals or seeking advice about postgraduate courses should provide the Bureau with information as to professional experience.

All communications should be sent to:

 The Medical Director International Medical Advisory Bureau Tavistock Square London, W. C. I, England

SEVENTH INSTITUTE ON SCIENCE IN LAW ENFORCEMENT

Western Reserve University, in Cleveland, Ohio, will hold the Seventh Institute on Science in Law Enforcement June 20-25, through the cooperation of the University's Law-Medicine Center and the Coroner's Office of Cuyahoga County, it was announced recently by Oliver Schroeder, Jr., director of the Center.

According to Schroeder, the institute will be comprised of 40 hours of lectures and demonstrations in criminal investigation and interrogation.

The crimes of homicide and burglary will be studied in depth with attention given to the improved techniques used by law-enforcement officers in the field and the laboratory.

The lectures and demonstrators include members of the Western Reserve University faculty, the professional staff of the Coroner's Office, experts from the Cleveland Police Department and others.

University housing will be available at \$15 for the week. Hotels and motels are also conveniently located. Tuition for the institute is \$75.

Many social events are planned during the week of the institute including a Cleveland Indians, New York Yankee baseball game, and a musical comedy production, "Anything Goes."

For further information contact: Oliver Schroeder, Jr., the Law-Medicine Center, 2145 Adelbert Road, Cleveland 6, Ohio.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

A unique fellowship program designed to further medical education by sending future doctors to remote areas of the world has been announced by the Association of American Medical Colleges.

Dr. Ward Darley, executive director of the AAMC, said the program would "Enable selected medical students to gain wide clinical experience as well as assist in the continuing war against disease in the backward areas of the world."

The three-year program, established under a \$180,000 grant from Smith Kline & French Laboratories, is open to all medical college students who have completed their third year of study, Dr. Darley said. Scheduled to begin this summer, the program will permit an average of 30 students to participate each year.

AMERICAN MEDICAL WRITERS' ASSOCIATION

ALL interested in medical writing, or any phase of medical communications, should make plans now to attend the big seventeenth annual meeting of the American Medical Writers' Association at the Hotel Morrison, Chicago, Illinois, next September 30 and October 1.

Dr. Austin Smith, former editor of the J.A.M.A. and now president of the Pharmaceutical Manufacturer' Association, is president this year, and is arranging an attractive program. Dr. W. D. Snively, Jr., of the Mead Johnson Co. of Evansville, Indiana, is heading an important conference on medical communication on October I.

Further details may be obtained from the Secretary, Harold Swanberg, M.D., W.C.U. Building, Quincy, Illinois.

ARTHRITIS AND RHEUMATISM FOUNDATION

The Arthritis and Rheumatism Foundation offers predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1961. Deadline for applications is October 31, 1960.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

NATIONAL EPILEPSY LEAGUE

The National Epilepsy League has announced that it will fill its members' prescriptions at cost. The service, believed to be an entirely new concept in national voluntary health agency programming, was announced by Howard R. Koven, Chicago attempts and populs elected chairman follows.

ming, was announced by Howard R. Koven, Chicago attorney and newly-elected chairman, following the league's twenty-first annual board meeting in Chicago.

"For some time now we have been investigating the cost and use of epilepsy medicine," Mr. Koven said. As a consequence, the league believed it should assume the responsibility of providing medicines to its members below the prices they now pay.

"By the inherent advantages of volume buying and dispensing of a limited number of medicines, significant savings are created for our membership. Furthermore, as a direct result of this money-saving service we hope to bring the newer, more effective and costlier medicines within the reach of all epileptics.

"It is our purpose to provide this service direct to epileptics at cost, with an annual membershipservice fee of \$1. Our accountants recommend that the plan be introduced with a 25 per cent reduction from regular prices. Quite naturally, in formnlating operating procedures strict ethical and legal controls have been installed to assure the highest professional standards."

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The medical research attack on cerebral palsy, a brain-centered disorder affecting control over voluntary muscles, is described by the U. S. Public Health Service in a new brochure.

"Cerebral Palsy—Hope through Research" explains some known causes of the disorder, describes the main types and extent of the condition, and reviews helpful treatment. The publication also tells of pioneering efforts to overcome this chronically disabling condition that affects more than half a million persons in the United States.

"Cerebral Palsy—Hope through Research" was written by the National Institute of Neurological Diseases and Blindness and is listed as Public Health Service Publication No. 713 and Health Information Series No. 95.

Single free copies may be obtained from the Public Health Service, Washington, D. C. Quantity orders cost \$3.00 per 100 copies from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Results of analyses of strontium-90 content of bones from 46 individuals in 6 Western States were announced recently by the Public Health Service, Department of Health, Education, and Welfare.

The Public Health Service said that when compared with previously published strontium-90 content of bones collected in various sections of North America and analyzed by the Lamont Geological Laboratory and the Atomic Energy Commission, the bones from Western States analyzed thus far do not show significant differences in strontium-90 concentrations. It was emphasized, however, that many additional samples are needed before definite conclusions can be drawn.

The announcement covered preliminary findings on a joint Public Health Service-Atomic Energy Commission research program to ascertain whether residents in Western areas of the U. S. are exposed to significantly greater amounts of radioactivity because of their proximity to the nuclear test site in Nevada.



VETERANS ADMINISTRATION

The Veterans Administration will cooperate fully in the new national campaign to eradicate tuberculosis in this country, Dr. William B. Tucker, director of pulmonary disease service for the VA in Washington, D. C., said recently.

The campaign was announced recently at the Arden House Conference in Harriman, N. Y., cosponsored by the Public Health Service and the

National Tuberculosis Association.

Dr. Tucker said the VA's role will be one of research and care of patients since the agency has no direct responsibility for public health measures. In accordance with the Arden House Conference recommendations, intensification of the VA's treatment program will make a large contribution toward control of the disease.

Definite favorable effects from use of the drug amphotericin-B in treatment of chronic histoplasmosis of the lungs, a fungus disease resembling tuberculosis, were reported by the Veterans Administration recently.

Dr. W. D. Sutliff of the Memphis, Tennessee, VA hospital said the finding is based on study of histoplasmosis patients from Tennessee, Mississippi, Missouri, Arkansas, and Kentucky who were treated at his hospital.

Despite the favorable results, cure with eradi-

cation of lesions was not achieved, toxic effects from the drug, though not serious, were common, and the treatment required prolonged hospitalization, Dr. Sutliff said.

He therefore recommended that the VA continue studies aimed at finding better treatment for the disease.

A palatable diet containing liquid vegetable fats instead of animal fats and solid shortenings has been developed at the Veterans Administration center in Los Angeles,

This study of fat in the diet, being made at the center, is perhaps the most comprehensive research program on this key question ever undertaken. The study is aimed at determining whether altered food habits can decrease the number of heart attacks and deaths from heart disease.

VA doctors hope to be able to determine whether substantial changes in fat-types in the diet, even at a comparatively late period in life, affect the incidence of heart attacks and strokes, and whether the long-term process of hardening of the arteries can be stopped or reversed.

SK & F Contributes to Education, Research

The Smith Kline & French Foundation gave \$735,611 to more than 200 organizations throughout the nation for charitable, scientific and educational purposes during 1959, according to a report released by trustees of the Foundation.

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1. Pomeranze, J. et al.: J.A.M.A. 171:252, Sept. 19, 1959. 2. Walker, R. S.: Brit. M J. 2:405, 1959. 3. Odell, W. D., et al.: A.M.A. Arch, Int. Med. 102:520, 1958. 4. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 5. Lambert, T. H.: ibid. 6. Skillman, T. G., et al.: Diabetes 8:274, 1959. 7. Sugar, S. J. N., et al.: Med. Ann. Dist. Columbia 28:426, 1959.





The Month in Washington

Defeat of the Forand bill in the House Ways and Means Committee highlighted developments on the issue of legislation to provide more Federal health care for the aged.

The Committee voted 17 to 8 on March 31 to shelve the Forand bill which would increase Social Security taxes to provide surgical benefits and limited hospitalization and nursing home care for Social Security beneficiaries, except the disabled.

However, the issue remained very much alive.

The Eisenhower Administration and Congressmen were separately considering various alternative proposals to provide additional health care for the aged, but outside the Social Security system. And the action of the House Committee did not rule out the possibility of Forand-type legislation being brought up in the Senate later this session.

The House Committee vote against the Forand bill came during the drafting of an omnibus measure of revisions in the Social Security program. The Committee voted tentatively to bring physicians under Social Security.

The Committee also favored elimination of the requirement that a disabled person must be 50 years or older to be eligible for Social Security payments.

Arthur S. Flemming, Secretary of Health, Education and Welfare, said the Administration was considering a plan for Federal payments to the states to help needy old persons buy private health insurance on a voluntary basis. He said he hoped the plan would be ready for submission to Congress by late April.

Sen. Jacob K. Javits (R., N.Y.) and seven other Republican Senators introduced similar legislation in the Senate. The bill called for the federal government and states jointly putting up about \$1 billion a year to help persons 65 years and older, and their spouses, to buy private health insurance. The coverage would include physicians care in home and office, diagnostic services, hospitalization and nursing home care.

Another plan being considered by some other members of Congress would broaden

the Federal-State public assistance program to provide more health care for needy older persons.

Both President Eisenhower and Vice President Nixon reiterated their opposition to any compulsory health plan such as the Forand bill. The President told a news conference that such plans would be a definite step toward socialized medicine. He proposed that medical care for the aged be improved through further development of voluntary health insurance programs.

Vice President Nixon gave his position in a letter to physicians who had communicated with him about the matter.

"The Vice President, throughout his career as a public official, has consistently opposed and will continue to oppose any compulsory health insurance program," the letter said. "This, of course, includes the Forand bill..."

"He believes that the best way to handle the problem of people over 65 who do not have and cannot afford health insurance is through a program which will enable those who desire to do so to purchase health insurance on a voluntary basis."

On the other side, three candidates for the Democratic nomination for President— Sens. John F. Kennedy (Mass.), Hubert H. Humphrey (Minn.) and Stuart Symington (Mo.)—said they would push for passage of Forand-type legislation.

The AFL-CIO continued its all-out campaign in support of the Forand bill. Leaders of the labor union repeatedly attacked the American Medical Association for opposing the bill.

One of the attacks prompted Dr. Louis M. Orr, Florida, to protest in a letter to AFL-CIO President George Meany against the union's "deliberate distortions of the truth, and outright untruths."

Dr. Orr charged that allegations in a political memorandum of the AFL-CIO's Committee on Political Education (COPE) "not only...attempt to impugn the motives and competence of the nation's physicians, but they seek to mislead labor's rank and file, the members of Congress, and the American people as a whole."

"When the AMA opposes any legislative health measure, it does so because its members believe that it would lead to poorer—not better—health care for the people of this country," Dr. Orr said.

From the Washington Office of the American Medical Association, 1523 L Street, N. W.

Senate Republican Leader Everett M. Dirksen (Illinois) also defended the AMA as well as the Eisenhower Administration, against the attacks when AFL-CIO leaders repeated them in testimony before the Senate Subcommittee on Problems of the Aged and Aging.

Senator Dirksen denounced them as "gratuitous slurs," "stinking statements," "invidious...insane charges" which constituted "an absolute disservice to the country."

Dr. James A. Appel, Lancaster, Pennsylvania, a member of the AMA Board of Trustees, testified before the Senate Subcommittee that the greatest health problem faced by older people is "their isolation from the rest of society." He said:

"The health problems of the aged can only be solved within the context of total health, they involve far more than hospitals or a doctors' care. They involve the older person's other requirements in life, whether these be housing, recreation, community understanding and acceptance, the right to be useful, the courtesy of being treated as individuals, or the opportunity of living as self-reliant, respected members of society."

As for an aged person being denied medical care because of a lack of money, Dr. Appel said emphatically:

"Medical care is available to every man, woman, and child in the United States regardless of his or her ability to pay for it.

"That care is not now denied, nor will it be denied."

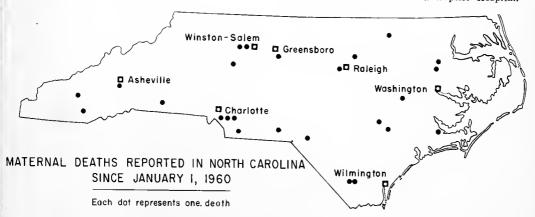
BOOK REVIEWS

Spiritual Therapy. How the Physician, Psychiatrist and Minister Collaborate in Healing. By Richard K. Young and Albert L. Meiburg, with an introduction by Clarence W. Hall. 184 pages. Price, \$3.50. New York: Harper & Brothers, Publishers, 1960.

This little book has a remarkable history. A paper by Drs. Richard K. Young and Benjamin S. Patrick, "Outpatient Pastoral Counseling in a Medical Center," was published in the Journal of he American Medical Association for September 6, 1958. Mr. Clarence Hall, senior editor of the Render's Digest, was so impressed with it that he made two visits to the North Carolina Baptist Hospital, the teaching hospital of the Bowman Gray School of Medicine, to collect material for a Digest article on the work of Chaplain Dick Young and his associates in the Department of Pastoral Care. In order to justify the length of the article, he published it in the Book Section of the Reader's Digest as the "condensed form of a forthcoming book," and extracted a promise from Dr. Young that he would write the book thus condensed. "Spiritual Therapy" is the result.

The book uses a new approach to the relation between physician and pastor in treatment. It is based on actual cases seen in the North Carolina Baptist Hospital. The effectiveness of the combined efforts of physician and pastor is shown by cases illustrating the following conditions: heart disease, ulcerative colitis, asthma, skin diseases, migraine, anxiety and conversion reaction, surgery, child-birth, the involutional period, and bereavement. A final chapter is devoted to the general hospital as a setting for spiritual therapy.

Every chapter was read critically for medical accuracy by a Bowman Gray faculty member who is an authority on the condition discussed. The final chapter was read by Mr. Reid Holmes, administrator of North Carolina Baptist Hospital.



The foreword by Dr. David Cayer, professor of gasteroenterology, and an introduction by Mr. Clarence Hall add to the value of the book.

The cases discussed illustrate how helpful to the patient is proper teamwork between the doctor and the minister. The auhors disdain the methods of the "faith healer," but emphasize the importance of bringing up to date Plato's view that the whole man and not the part must be treated.

Its common sense, down to earth discussion of the sort of every day problems that are common meeting grounds should make the book of interest to both physician and pastor—and even to patients. The authors deserve commendation for an excellent job.

In Memoriam

Earl Runyon Tyler, M.D.

Dr. Earl Runyon Tyler, the son of Marie Teresa Caravati and James Dawson Tyler, was born January 23, 1899, in Richmond, Virginia. He married Miss Beryl Jones on October 29, 1932. He is survived by his wife and three children, Earl Runyon Tyler, Jr., James Dawson Tyler, Anne Madison Tyler.

He was graduated with a B. S. degree in medicine from the University of North Carolina two-year medical school in 1920 and received his M.D. degree from Jefferson Medical College in 1923.

After graduating from Jefferson Medical College in Philadelphia in 1923, he served one year's internship at St. Vincent's Hospital, Erie, Pennsylvania. Following this he did country practice in Franklinville, North Carolina, for two years.

At the end of this period he decided to specialize in dematology. For this training he went to the University of Pennsylvania in Philadelphia, where he studied for two years, 1926-1928, under Dr. John H. Stokes, one of the finest dermatologists in the country. In this work he made an excellent record, and before leaving was considered one of the most promising of the younger men in the department. A student at Pennsylvania at that time stated that if any of the students wished to know something, they would go to Runyon rather than to one of the professors.

After leaving Philadelphia in 1920, he came to Durham and began the practice of dermatology. He soon became known in North Carolina and surrounding states as one of the leading authorities in his field. He held this enviable reputation until his death on February 19, 1960.

During his second year in medicine at the University of North Carolina, he was president of his class. He was a member of the Durham-Orange County Medical Society, the North Carolina Medical Society, the American Medical Association, the North Carolina Dermatological Society, the

South Eastern Dermatological Association, the Baltimore and Washington Dermatological Society and the Society for Investigative Dermatology. He worked with the selective service during World War II. He was a member and founder of the Kennel Club in Durham, and was a member of the Episcopal Church.

There were several fundamental reasons for his success. In the first place, he had a wonderful mind. He was one of the most brilliant men we had in our profession. He not only knew dermatology, but he kept himself informed about what was going on in other medical specialties. His years in general practice undoubtedly helped make him the great therapist that he was. People came from far and near to see him; his patients got well.

He had many great traits, but one of the greatest was his honesty. There was no sham or pretension about him. He believed in calling things what they were. Truth fitted him as naturally as his smile. He had no use for a lie.

He unquestionably saw more referred patients than any man in town, and yet no one who asked for his help failed to receive it. He had many friends and, as far as we know, no enemies. The sands of time will preserve his footprints for many a day.

Hunter Sweaney, M.D. W. R. Stanford, M.D.

Lilly Introduces New Analgesic

Darvo-Tran, a new analgesic product for the relief of pain accompanied by tension and anxiety, has been introduced by Eli Lilly and Company.

To the potent analgesic action of Lilly's Darvon and A.S.A. it adds the mildly tranquilizing effect of Lilly's Ultran.

Classified Advertisements

DESIRABLE LOCATION for a physician. Contact Godley Realty Company, Mt. Holly Road, Charlotte, North Carolina.

PHARMACIST experienced in retail and hospital, desires to contact doctor(s) to establish clinic pharmacy. Replies kept strictly confidential. Box 790, Raleigh, N. C.

WANTED: North Carolina licensed physician to join full time industrial staff in North Carolina. North Carolina plant of nationwide corporation. Work primarily preventive medicine. Well equipped medical section. Staff of 2 physicians, 5 nurses, 1 technician. Send resume to 54-10 P. O. Box 790, Raleigh, N. C. All correspondence strictly confidential.

SITUATION WANTED: Anesthesiology Board eligible. American born: Class A graduate. Six years general practice experience prior to Anesthesiology residency. Available June 1, 1960. Box 790, North Carolina Medical Journal, Raleigh, North Carolina.

The first specific aldosterone-blocking agent \dots

$ALDACTONE^{*}$

effectively extends the medical control of edema or ascites. It introduces a new therapeutic principle in the treatment of...

CONGESTIVE HEART FAILURE . HEPATIC CIRRHOSIS
THE NEPHROTIC SYNDROME . IDIOPATHIC EDEMA

ALDACTONE introduces a new class of therapeutic agent, the aldosterone-blocking agent providing:

satisfactory relief of resistant or advanced edema even when all other agents, alone or in combination, are ineffective or are only partially effective.

A New Order of Therapeutic Activity

ALDACTONE acts by blocking the effect of aldosterone, the principal mineralocorticoid governing the reabsorption of sodium and water in the distal segment of the renal tubules.

By so doing Aldactone establishes a fundamentally new and effective approach to the control of edema or ascites, including edema resistant or unresponsive to conventional diuretic agents.

Further, because of its different site and mode of action in the renal tubules, Aldactone has a true, highly valuable synergistic activity when used with a mercurial or thiazide diuretic.

What Physicians May Expect of Aldactone

It is fully expected that Aldactone will change present medical concepts of the therapeutic limitations of managing edema. Many patients living in a greater or lesser state of edematous invalidism can now be edema-free. To others, gravely ill, Aldactone will be life-saving.

When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

When Aldactone is used in a comprehensive therapeutic regimen, which includes a mercurial or a thiazide diuretic, a satisfactory diuresis and relief of edema may be expected in approximately 85 per cent of edematous patients who would not otherwise respond.

DOSAGE: For most adult patients the optimal dosage of Aldactone, brand of spironolactone, is 100 mg. four times daily. Aldactone should be administered for at least four or five days before appraising the initial response, since the onset of therapeutic effect is gradual when it is used alone. Aldactone manifests accelerated activity with greater response as early as the first and second days when used in combination with a mercurial or thiazide diuretic.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of I00 mg.

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DELALUTIN

SOUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy



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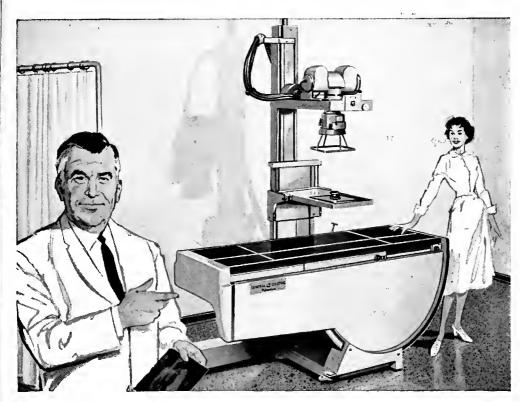
Complete information on administration and dosage is supplied in the package insert

supply: Wials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzel benzoate and sesame oil. Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzel alcohol.



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Repeatedly it has been demonstrated that Butazolidin; Within 24 to 72 hours produces striking relief of pain. Within 5 to 10 days affords a matked improvement in mobility and a significant subsidence of inflammation with reduction of swelling and absorption of effusion.

Even when administered over months or years Butazolidin does not provoke tolerance nor produce signs of hormonal imbalance.

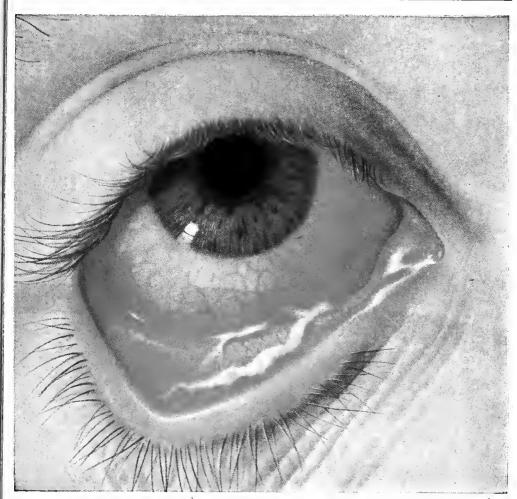
Butazolidin® brand of phenylbutazone: Red-coated tablets of 100 mg. Butazolidin® Alka. Capsules containing Butazolidin® 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 130 mg.; homatropine methylbromide 1.25 mg.

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no irritating crystals uniform concentration in each drop STERILE OPHTHALMIC SOLUTION

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1. Lippmann, O.: Arch. Ophth. 57:339, March 1957.
2. Gordon, D.M., Am. J. Ophth. 46:740, November 1958. supplied: 0.5% Sterile Ophthalmic Solution NEO-HYOELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL". In 5 cc. and 2.5 cc dropper valls. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

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KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per tsp. (5 cc.). Bottles of 4 and 16 fl. oz.

New for acute G. U. Infection AZO KYNEX Tablets (for q. i. d. dosage), 125 mg. KYNEX sulfamethoxypyridazine in the shell with 150 mg. phenylazodiaminopyridine HCI in the core.



1. 8oger, W. P.; Strickland, C. S., and Cylle, J. M.; Antibiotic Med. & Clin. Ther. 3:378 (Nov.) 1956. 2. 8oger, W. P.: In: Antibiotic Annual 1958-1959, Medical Encyclopedia. Inc., New York. 1959, p. 48, 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.; Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1959. 4. Anderson, P. C., and Wissinger, H. A.:
U. S. Armed Forces M. J. 10.1051 (Sept.) 1959.

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FOR ACNE NEW HISOAC* PHISOAC* CREAM

Therapeutic topical application suppresses and masks lesions. Dries, peels, degerms the skin. Used with **pHisoHex**® (antiseptic detergent) washings to unplug follicles, help prevent comedones, pustules and scarring.



Teen-agers like new pHisoAc Cream. It is smooth, odorless, flesh-toned, and greaseless. It spreads and dries quickly. Ask the Winthrop representative for the special booklet, "Teen-aged? Have acne? Feel lonely?," containing basic home treatment routine and psychological aid for the patient.

New pHisoAc Cream contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, hexachlorophene 0.3 per cent, orthophenylphenol 0.3 per cent, and alcohol 10 per cent (w/w). Available in 1½ oz. tubes.

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51 to 49...it's a boy!





94 to 6 BONADOXIN stops morning sickness

When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male. But when she mentions morning sickness, your course is clear: BONADONIN.

For, in a series of 766 cases of morning sickness, seven investigators report excellent to good results in 94%. More than 60 million, of these tiny tablets have been taken. The formula: 25 mg. Meclizine 11Cl (for antinauseant action) and 50 mg. Pyridoxine HCl (for

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BONADONIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis. Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness, See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept, HEW, Vol. 48, No. 14, 1958, p. 398. 2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.



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Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Eayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best testing aspirin over made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

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 We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children. New GRIP-TIGHT CAP for Children's Greater Protection







Colitis? Gall Bladder Disease? Chronic Appendicitis?

Rheumatoid Arthritis? Regional Enteritis?

DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.¹

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.²

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.³

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of Simarouba glauca, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat

suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubinindicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

- 1 Cook, J.E., Briggs, G.W., and Hindley, F.W., Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig. of Treat. 6:1821 (Dec., 1955).
- 2 Rinehart, R.E., and Marcus, H. Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., 54:708 (July, 1955).
- 3. Webster, B.H., Amehiasis, a Disease of Multiple Manifestations, Am. Pract and Dig. of Treat. 9:897 (June, 1958).
- °U S. Pat. No 2,864,745

THE S.E. MASSENGILL COMPANY

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for more normal living in angina pectoris

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with 50 mg. Secobarbitai

Reduces incidence and Severity of attacks

Continuous release Antora capsules give long, sustained therapeutic effect that reduces the number and severity of attacks, lowers nitro-glycerin requirements.

With reduced fear of attack your patient is encouraged to participate in activities to his allowed capacity.

Prescribe

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Available in bottles of 60 and 250 capsules.

· Effects sedation without mental or physical slow down

 A low dosage of Secobarbital is gradually released with Antora over a 10-12hour period to reduce the anxiety complex. Antora-B also minimizes insomnia due to pain and shortness of breath on effort.

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IN THE NEW, CHERRY-FLAVORED SYRUE

75 mg./5 cc. tsp., in 2 fl. oz. bottle-3-6 mg. per lb. daily in four divided doses

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For topical infections, choose a 'B. W. & Co." 'SPORIN'...



Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units Neomycin Sulfate in a special petrolatum base.

Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

Each gram contains:

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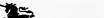


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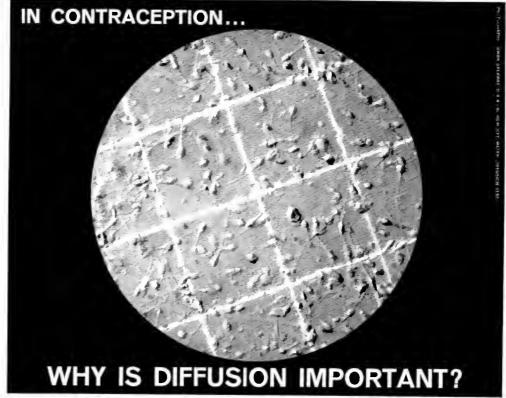
Polymyxin B Sulfate 10,000 Units in a special petrolatum base.

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Because the active ingredients of a spermicidal preparation must diffuse rapidly into the seminal clot and throughout the vaginal canal to be clinically effective. Lanesta Gel offers this dual protection. Its four spermicidal agents quickly invade the clot to stop the main body of sperm. It spreads evenly and quickly throughout the vaginal canal—seeks out every wrinkle and fold that may offer concealment to sperm. With this rapid diffusion, your patient receives full benefit of the swift spermicidal action of Lanesta Gel—in minutes—a decisive measure in conception control.

In Lanesta Gel 7-chloro-4-indanol, a new, effective, nonirritating, nonallergenic spermicide, produces immediate immobilization of spermatozoa in dilution

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Lanesta Gel with a diaphragm provides one of the most effective means of conception control. However, whether used with or without a diaphragm, the patient and you, doctor, can

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spermatozoa.

Lanesta Gel

Supplied: Lanesta Exquiset[®] . . . with diaphragm of prescribed size and type; universal introducer; Lanesta Gel, 3 oz. tube, with easy clean applicator, in an attractive purse. Lanesta Gel, 3 oz. tube with applicator; 3 oz. refill tube — available at all pharmacies.

A product of Lanteen® research.



Maximal Absorption Acid stable, highly soluble

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May be administered without regard to meals. However, highest absorption is achieved when taken just before or between meals.

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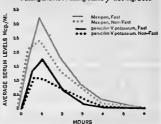
Indicated in infections caused by streptococci, pneumococci, susceptible staphylococci, and gonococci

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NOTE: To date, MAXIPEN has not shown less allergic reactions than older oral penicillins. Usual precautions regarding penicillin administration should be observed.

SUPPLIED: MAXIPEN TABLETS, scored, 125 mg. (200,000 units), bottles of 36; 250 mg. (400,000 units), bottles of 24 and 100 tablets. MAXIPEN FOR ORAL SOLUTION; reconstituted each 5 cc. contains 125 mg. (200,000 units), in 60 cc. bottles.

COMPARATIVE ORAL SERUM LEVELS* Fasting and Non-Fasting States / 250 Mg. Dose



*Based on 3294 individual serum antibiotic determinations. Complete details available on request.

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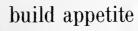
Geroniazol TT* b.i.d.

- Each Geroniazol TT tablet contains:
 Pentylenetetrazol300 mg.
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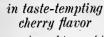


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Average dosage, 1 teaspoonful (5 cc.) contains:

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Because of the infrequency of the disease in this age group, its sudden onset, the profusion of inconsistent presenting symptoms, and because the accompanying symptoms of anorexia and vomiting are also characteristic symptoms of many other ills of infancy.

*Source: Traisman, H. S.; Boehm, J. J., and Newcomb, A. L.: Diabetes 8:289, 1959.

for those pediatric puzzlers..."A routine urinalysis and blood sugar should be done whenever the possibility of diagnosing diabetes is entertained."*

the standardized urine-sugar test for reliable quantitative estimations

DIABETES MELLITUS AT AGES 1 TO 5

Order of Frequency of Presenting Symptoms in 110

Symptoms	No. of Patients	Per cent of total group
Polyuria	93	84.5
Polydipsia	89	81.0
Weight loss	47	42.7
Polyphagia	28	25.4
Anorexia	16	14.5
Lethargy	14	12.7
Enuresis	7	6.4
Vomiting	S	4.5
Irritability	3	2.7
"Craving for sweets"	3	2.7
"Sticky diaper"	3	2.7
"Strong odor to urine"	2	1.8
Glycosuria	2	1.8
Hypoglycemia	2	1.8
Personality change	1	0.9
Boils	1	0.9
Headache	1	0.9
Abdominal cramps	1	0.9

Adapted from Traisman, H. S.; Boehm, J. J., and New-

- · full-color calibration, clear-cut color changes
- established "plus" system covers entire critical range
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Tofrānil

In the treatment of depression Tofranil has established the remarkable record of producing remission or improvement in approximately 80 per cent of cases.

Tofrānil is well tolerated in usage is adaptable to either office or hospital practice—is administrable by either oral or intramuscular routes.

Tofranil

a potent thymoleptic... not a MAO inhibitor.

Does act effectively in ..., types of depression regardless of severity or chronicity.

Does not inhibit monoamine oxidase in brain or liver; produce CNS stimulation; or potentiate other drugs such as barbiturates and alcohol.

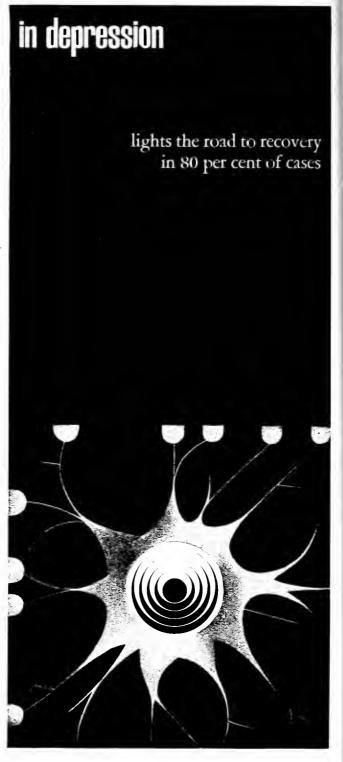
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Totrand's brand of impramine HCl tablets of 25 mg., britles of 100. Ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution, earth os of found 50.

Perkrev, et al. Avd. F.J., Ir. Buil School Medi., Univ. Marcland 4-10, 1959. 2. Azima, H., and Vispo, R. H.: A. M. A. Arch. Neurol. & Psychiat 871088, 1959. 3. Lehmann, H. E. Cahn, C. H., and de Verteul, R. L. Canad. Psychiat A. J. 3. 185, 1958. 4. Mann. A. M., and MacPhersin, A. S. Canad. Psychiat. A. J. 3. 85, 1959. 5. State, R. B., Habb, A. and Bair, L. E. Canad. M. A. J. 50, 340, 1959. 6. Straker, M. Canad. M. A. J. 54, 1950. 7. Strauss, H.: New York J. Med. 1972905, 1959.

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When he is totally disabled by accident or sickness covered by this plan, this plan will give him emergency income, free of Federal income tox, eliminating the nightmare coused by a long disability.

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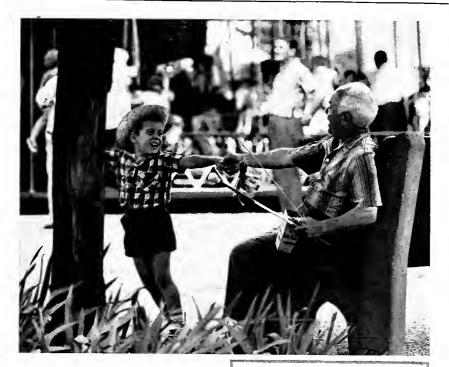
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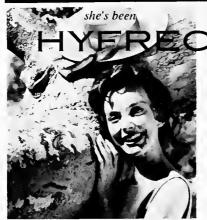
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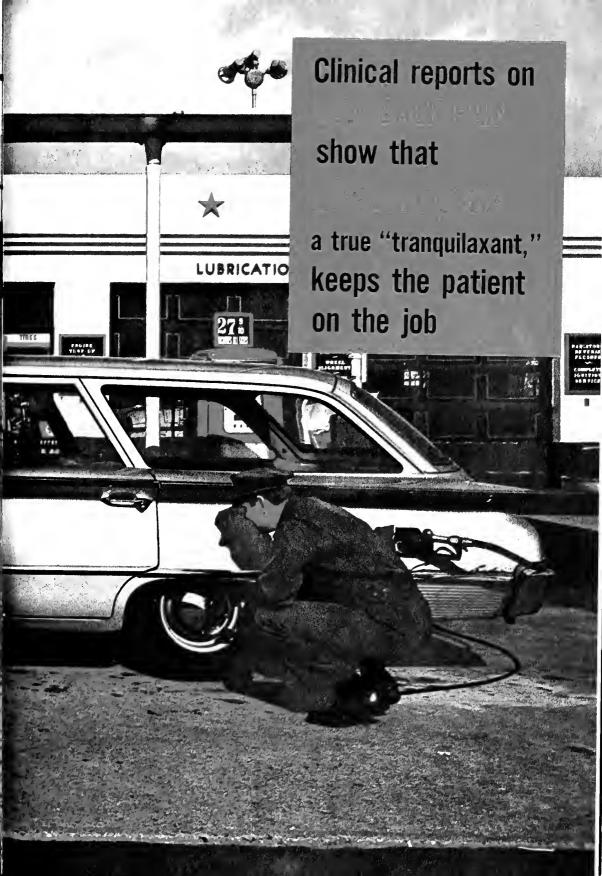
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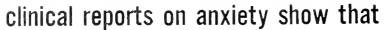
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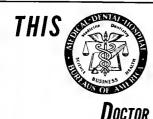




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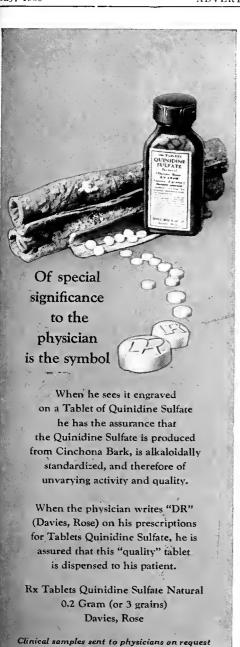
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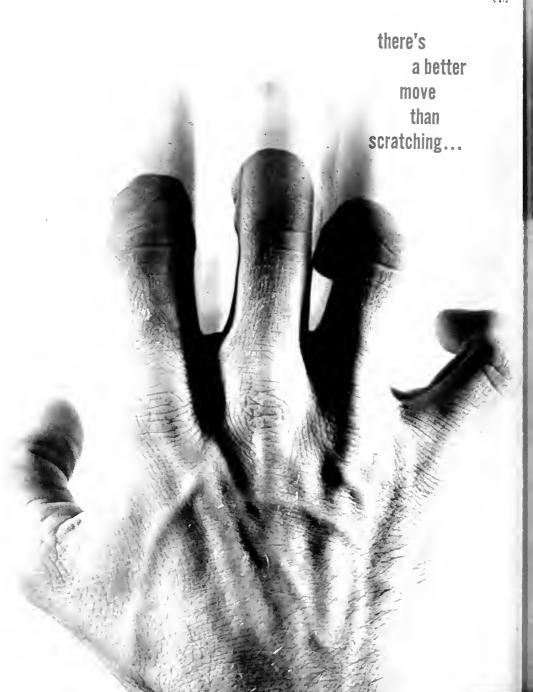
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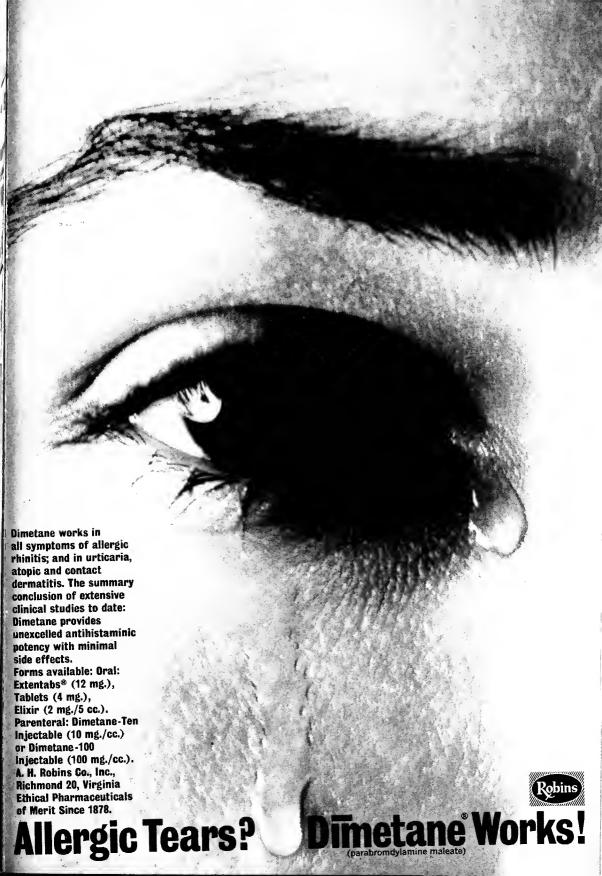
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Recent JAMA editorial statement clarifies the current controversy about dietary fats

Excerpted from the March 12, 1960, issue of The Journal of The American Medical Association:

66 It is accepted generally that specific alteration in the diet will lower the concentration of cholesterol in the blood. The most effective results to date have been achieved by increasing consumption of polyunsaturated fatty acids, particularly linoleic acid. However, indefinitive and conflicting information has left much to the imagination of some food processors. Some of the largest vegetable oil processors in the United States have implied in advertisements that the cholesterol level can be lowered merely by adding polyunsaturated fatty acids to the diet. This selling campaign has created confusion among lay people, making it increasingly important that the physician clarify for his patients the conditions under which changes in the diet will be effective.

The patient should understand that if he increases his consumption of polyunsaturated fatty acids without reducing his intake of other fats, little is gained save for additional calories which could lead to obesity. A particular regimen will be effective only if polyunsaturated fatty acids are responsible for an appreciable percentage of the total fat calories. That is, they must replace rather than supplement some of the saturated fats and oils already in the diet.

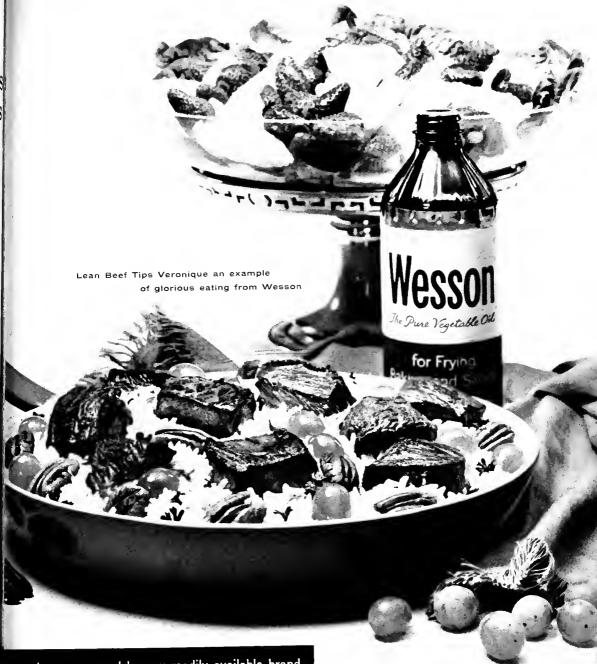
Some manufacturers cite the "iodine number" of a fat or oil as evidence of the

unsaturated fatty acid content of their product. This number is not a reliable indicator of therapeutic value because it measures monounsaturated and polyunsaturated fattyacid content at the same time. A monounsaturated acid, like oleic, takes up two iodine atoms but does not affect the cholesterol concentration of the blood. A polyunsaturated acid, like linoleic, takes up four iodine atoms. In a product containing large amounts of oleic acid and small amounts of linoleic acid, the iodine number is nearly the same as it would be for a product containing little oleic acid and a modest amount of linoleic acid. Cottonseed oil has an iodine number of 110 and corn oil a number of 127; yet they each have about the same amount of linoleic acid.

Low-fat diets will not reduce the concentration of circulating cholesterol and lipoproteins as effectively as will diets containing an adequate percentage of polyunsaturated fatty acids. Weight-reduction regimens are basically low in fat, and if a lowered cholesterol level is necessary, planning must be done to maintain the proper ratio of saturated to unsaturated fats.

Herbert Pollack, M.D. Associate Professor of Clinical Medicine Postgraduate Medical School New York University, New York

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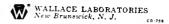
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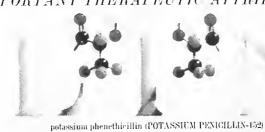
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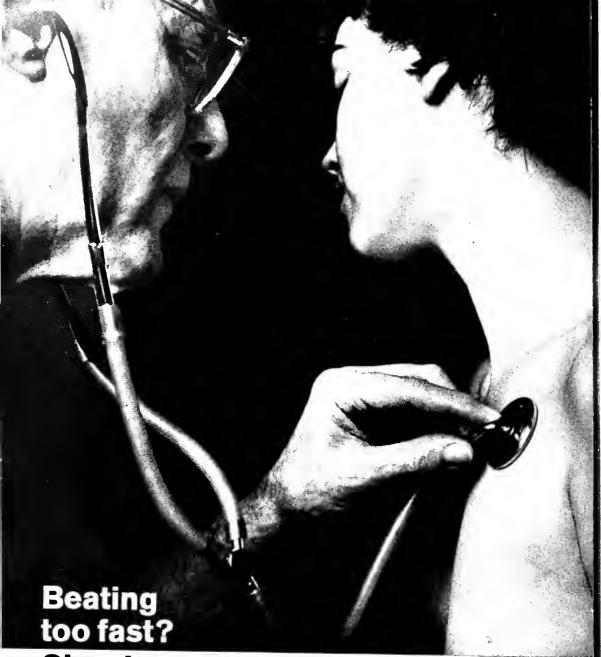
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Settel, E.: Am. Pract. & Digest Treat. 8:1584 (Oct.) 1957. Negri, F.: Minerva med. 48:607 (Feb. 21) 1957. Shalowitz, M.: Gerl-atrics 11:312 (July) 1956.

Elsenberg, B. C.: J.A.M.A. 169:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. 64:2239 (Oec. 26) 1956. Robinson, H. M., Jr., et al.: 5outh. M. J. 50:1282 (Oct.) 1957.

Garber, R. C., Jr.: J. Florida M. A. 45:549 (Nov.) 1958. Menger, H. C.: New York J. Med. 58:1684' (May 15) 1958. Farah, L.: Inter-nat. Rec. Med. 169:379 (June) 1956.

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VOLUME 21

JUNE, 1960

No. 6

President's Farewell Address

JOHN C. REECE, M.D.

MORGANTON

This, I am sure, is the address that each president of the Medical Society reflects upon the most-the traditional farewell message.

The inaugural address, formally accepting the high honor of the presidency and outlining goals he hopes to reach during his term of office comes more readily in the high stimulation of the moment. Then his address prepared a year later for delivery before the House of Delegates in which he reviews the accomplishments of the Society during his tenure is more easily prepared because it relates to more tangible and measurable activity. This review is also made easier when he has had the splendid cooperation that I have had. But when it comes time to say farewell, words do not flow so freely except for a fervent and sincere "thank you."

Medicine has had a long and eventful history. There is probably no more fascinating story than that of the rise of scientific medicine. Its beginnings were veiled in mystery and superstition; its progress was encumbered by ignorance and quackery. Above these it has risen to become the most beneficial branch of modern science.

The Heritage of the Past

The story of medicine is that of a long and difficult struggle with the mysteries of life; a struggle which has brought about outstanding achievements in the prevention and cure of disease, the amelioration of human suffering, and the prolongation of life.

the great phenomena of all time. It has transcended its original narrow limits to become a guiding force in modern civilization, bringing with it outstanding medical

Medicine in our country today is one of

centers, excellent schools, a vast hospital system with small efficient units even in remote areas, better trained physicians serving in rural as well as urban areas, skilled researchers working in elaborate technical laboratories, modern scientific facilities for the development of new drugs, and research programs which go far beyond our earlier dreams.

With all of this we can proudly say that the medical profession has met the challenge of each new era. Many have contributed to the development of our great medical system, and to them we are indebted for this heritage. We are indebted also to our predecessors for including in the American system of free enterprise the practice of medicine and man's freedom of choice.

The Challenge of the Present

Today, however, the medical profession faces a new and formidable challenge, perhaps the greatest yet. We must resolve to strive valiantly to preserve this heritage which has meant so much to the health and welfare of all Americans. We must continue to do battle for what we consider to be in the best interest of all men; we must continue constantly to study the great patientphysician relationship, remembering that we are dealing with the lives and health of individuals; and we must seek to remove the impression that we are reactionaries opposed to any change.

For a profession which has witnessed changes greater than any other, it is interesting to speculate how we have become known as a group strongly opposed to change and committed to preserving the status quo at all costs.

The medical profession has accepted change, for change is inevitable, but we have never advocated change just for change's sake. There are certain unalter-

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able principles in our profession which date back to Hippocrates. It was he who separated medicine from mystery and superstition and who used the bedside method which was to become the distinctive attribute of all great physicians. His attention was centered upon the man as well as the disease, and he kept in his practice a balance between science and art which was to be the distinguishing quality of all great clinicians in all ages. "To know," he said, "is one thing; merely to believe one knows is another. To know is science, but merely to believe one knows is ignorance." It was a difficult path that he pointed out for medicine to follow, one that involved intellectual honesty; for only the highest types of men have the intelligence, the independence, the integrity, and the courage to admit their errors and seek the truth without bias. Such are they who have given us modern medicine.

Conservation and change

Perhaps we have failed to distinguish between that which should be constantly changed and improved and that which should remain basically intact as far as the public is concerned. Through 24 centuries of transition, physicians have moved out into broader fields in guarding the world against disease. Through these centuries, although mystery has given way to science, a science exerting today the strongest force in civilization for human betterment, we have never yet discarded the religious principles of sacrifice of self to others, principles older than science. As long as human beings remain human, the contact of personality must remain an integral part of the practice of medicine. It is not to industry, government, or social planning that we turn when in pain, but to the only one who is qualified to heal-the trained physician.

It may be that we have been so engrossed in the rapid progress of medical science as far as its application to individual patients is concerned that we have allowed ourselves to lose sight of the broad field of medicine. As a result we may get on the defensive when social-minded do-gooders and vote-minded demagogues propose changes which would alter the medical world as we know it today.

They accuse us of opposing without having any answer of our own for whatever problem they are considering. We do not need to come up with a new plan. We already have the best possible answer—the American system of unregimented medical practice in which the patient is free to choose his own physician. It is a system which represents American free enterprise at its best, and it has been a basic part of the development of medical science to the highest levels of patient service the world has ever known.

"Selling" the American System

Because we know this, we take it for granted that everybody else knows it too. Perhaps we have neglected, while bringing the latest in medical science to our patient, to see that he is informed of the excellence of the system under which he is cared for, and that it is he more than we who will benefit from its perpetuation. We are told that we are good doctors when it comes to looking after the individual patient; but because we have neglected to inform our patients and the public, in the broad sweep of the total medical picture we are called arch reactionaries, selfishly determined to withstand any change in our profession. We have been too aloof from proposals which threaten the American medical system, failing to explain what all Americans stand to lose under revolutionary plans.

As informed citizens dealing with the health of the nation, we should let the public know that we are on their side in the great fight for health. Remembering that we were citizens of some community before we became physicians, we should become active in the affairs of our community, state, and nation, letting friends, neighbors, and fellow workers know that we practice the role of citizens as well as physicians.

Because of our inactivity in civic and governmental affairs, too many citizens have listened to the political pied pipers, so that now it seems that the whole nation is trying to practice medicine by prescribing for the body politic, just as if it rather than the men who know were in a better position to judge what medical system is best for the country. In this tendency the nation is not unlike the patient who walks into the

doctor's office and declares, "I need a shot of penicillin." He may have anything from a headache to fallen arches, but with his limited knowledge he thinks a "shot of penicillin" is the answer.

Responsibility for the Future

In advocating a strong and positive effort toward "selling" the American medical system, I may sound as if I were proposing simply a glorified public relations program. But it is far more than that.

I said earlier that change is inevitable. Our great medical system, which should be preserved, must be broad and flexible enough to meet aggressively the social and economic problems facing the country. These are fields in which changes must come, but not in the system itself.

At present we are confronted with the problems of the aging. Medical science is responsible for increasing life expectancy and giving the country the greatest proportion of older residents that it has ever had. Our State Society and the American Medical Association are devoting much study to the needs of the aged and chronically ill. Out of this sincere concern for a growing segment of our population should come an acceptable plan by our profession and not the government to help meet the medical needs of the aged. This is just one of the socio-economic problems we must face aggressively, as physicians and as good citizens.

We have never accepted the word "defeat" in regard to disease, and if we are to follow the example of our professional ancestors, we must not accept defeat in regard to the practice of medicine and its ability to meet whatever challenges lie ahead without sacrificing the spirit and principles of our calling.

If our attitude becomes one of negation and defeatism, we will be brushed aside and consigned to a regimented bureacracy which will tell us what and how to practice medicine and who our patients will be, whether they want our services or not. Change will overwhelm us unless we are willing and ready to abandon our aloofness and help shape the changes which will surely come. Therefore we will continue to be heard as we rally around a cause which we deem to be in the best interest of all citizens.

Remembering our great heritage in medicine — the sacrifices, the ambitions, the hopes and achievements of dedicated men, past and present—we must pledge ourselves to preserve and to pass on to future generations of physicians the courage necessary to meet any challenge of medicine in any age.

We must seek the wisdom to help direct and fashion the affairs at hand to the end that our patients receive the very best health care and in no way are exploited for political expediency. Exploitation in our profession is called quackery, and it is no less when it is done by others.

Above all, we must see that the public recognizes the eternal truth that physicians are the guardians of the health of men, a truth that has been tried and proven on a person-to-person basis and which we as a profession must preserve in its broadest application to the total health of the nation.

With high vision and aggressive courage, our great Medical Society will be capable of meeting the challenge of our day.

Today too many people are having their symptoms masked by too many drugs. Never before have so many people received so much unnecessary quieting, stimulating, and harmful psychiatric medication. As a result, people in the United States are in danger of becoming psychiatric zombies. Before we give these drugs or employ electroshock, let us first find out what is causing a patient's illness and try to remedy his condition permanently.—Terhune, W. B.: Office Management of Psychiatric Problems, Med. Ann. District of Columbia 28:307, 1959.

Public Health Assists the Private Physician

JOHN R. BENDER, M.D.*

WINSTON-SALEM

Within the past four months. I have read two editorials in medical journals from other states, in which scathing criticism was aimed at the entire system of public health—from top to bottom and from bottom to top.

Editor number one would have his readers believe that the physician in private practice has spread himself so thin in his eagerness to serve humanity that he has welcomed an opportunity to let someone else, either individual or group, within or outside the medical profession, "take over for a spell." And by so doing, he now finds that he is being gradually destroyed by the exploits of technical experts, reformers, political bureaucrats, and socialistic agencies, taking over one disease and then another.

Editor number two was even more militant in expressing his resentment against "certain policies and practices of the local health department actively engaged in the private practice of medicine." "These infringements," he said. "are the handiwork of the local health directors, who are receiving tacit endorsement for their culpability by those in higher echelons (in the State Department)."

"The basic philosophy of this agency is socialistic," the editorial continues. "and its present position behind sacrosanct bastions is seemingly secure from reprisals."

My only reason for mentioning either of these editorials is that there are some physicians practicing in North Carolina today, perhaps even a few in this audience (yet I doubt that), who have the same feelings of resentment and make the same garrulous criticism of the State Board of Health and the local health departments in North Carolina as were expressed in these editorials.

As a member of the State Board of Health, I am, therefore, a party to and a part of this socialistic agency which condones the usurpation of the practice of medicine by the local health departments! What can I do to atone for being accessory to an agency so vile as to be guilty of the following crimes?

Achievements of the Past Year

- 1. We have worked unceasingly with Dr. Sam Ravenel and his committee of the Medical Society of the State of North Carolina during the 1959 Legislature to get a law-making vaccination against poliomyelitis for pre-school age children mandatory!
- 2. The Division of Epidemiology of the State Health Department, is constantly alert to changes in the incidence of communicable diseases and compiles weekly reports of communicable diseases for the sake of medical and public interest, and also for national comparisons. Through such a compilation. interesting data are gathered for use by the local health director and the private practitioner, to warn of and prepare against possible approaching epidemics. In comparison with 1958. North Carolina had in 1959, for instance, 1,199 more cases of measles, 176 more cases of whooping cough, twice as much infectious hepatitis, and more than seven and one-half times the number of cases of paralytic poliomyelitis (37 to 270). Fifty-six per cent of the paralytic cases were in children under 4 years of age, and less than 2 in 5 of all recorded cases of poliomyelitis had received any Salk vaccine.

Intensive investigations of all cases of typhoid, malaria, diphtheria, tularemia, brucellosis. Q fever, and other infections were made: and a large number of studies relating to food-borne illnesses were conducted.

3. Statistical requests and consultative assistance reached an all-time high in 1959. The State Board of Health is the custodian of reports of morbidity, mortality, divorces, natality, and other information for the entire State. Therefore, it assists professional and lay agencies in compiling data for research projects. At the present time it (the State Board of Health) is cooperating with the Medical Society of the State of North

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Carolina through its committees in supplying information for five research projects; (1) North Carolina Hospital Survey; (2) Neonatal Death Study; (3) Maternal Health (4) Auto Crash Injury Research; and (5) Anesthesia Study.

Within the past decade there has been a reversal of the trends of causes of death in North Carolina. Tuberculosis, which has heretofore been one among the 10 greatest killers within this state, was responsible for only 208 deaths in 1959. But as the morbidity and mortality from the communicable and infectious diseases becomes less and less, the State Board of Health becomes more and more concerned with the problems of chronic and degenerative diseases, such as early cancer detection, protection against cardio-vascular-renal damage, and prevention of mental and nervous breakdowns. We also find increased emphasis on maternal health, congenital defects, handi capped children, occupational health, improved and revised standards of sanitation, food-borne diseases, and many other problems and programs that have direct influence upon the properties, industries, health, and life of the people of this state.

4. The State Board of Health, through its Occupational Health Section, serves in planned engineering and medical activities with the Department of Labor and the Industrial Commission, permitting closer coordination of health services with industrial programs. Last year the industrial hygiene engineers inspected more than 300 plants (10 per cent more than in the previous year) for dusts, fumes, chemicals, vapors, ionizing radiation, and other health and occupational hazards.

The Section also co-sponsored seminars on ventilation at North Carolina State College and in radiologic health and industrial nursing at the University of North Carolina, and was assigned the major responsibility in coordinating the radiologic health program as required by law through

1959 legislation.
5. The Veterinary Medical Section of the State Board of Health is cooperating with the Department of Agriculture in investigating diseases of animals transmissible to man. One big project for the past two years was to determine the degree of contamination in poultry processing plants with various species of Salmonella organisms. In

one plant, a total of 32 per cent of processed fowls were infected with these pathogens. The Veterinary Section continues to strengthen its program in the eradication of rabies, which has been a major health problem in several counties of the State the past year. The Department continues consultative cooperation with the Department of Agriculture in problems of mutual concern (such as meat and milk inspections) aimed at producing wholesome high quality food products of animal origin.

- 6. Accident prevention is becoming one of North Carolina's major public health activities. In an effort to reduce death and injury from farm and home accidents, the Accident Prevention Section, State Board of Health, continues its educational program on accident prevention for public health workers, home demonstration club leaders, 4-H club groups, Parent-Teacher Associations, civic clubs and other community workers.
- 7. Nervous and mental disorders are gradually consuming a larger portion of the private practitioner's time and making greater demands upon local health authorities each year. In 1959, 11 mental health clinics held more than 32,000 patient interviews. Forty-nine per cent of these patients were under 18 years of age. The Mental Health Section also provided consultation service to schools, courts, industries, welfare departments, doctors, ministers, nurses, and other groups and agencies. Mental health clinics were established in two additional county health departments, and part-time assistance was supplied to three others.
- 8. The State Board of Health operates under the philosophy that, following preventive efforts, early detection and correction of defects is the next step toward good health. It finds its best application of this philosophy through the Division of Oral Hygiene and Crippled Children's Clinics of the Personal Health Division.
- a. The program of dental health serves the children of elementary school age with the aim of teaching all children the importance of actively seeking good dental health. A program was initiated during the past year for the collection of base line data on the dental condition of children of school age in areas which are just beginning fluoridation, and in areas where fluorida-

tion has been in operation several years. From data thus obtained, indications are that in areas where fluoridation has been present for five years, the decay rate among children between 6 and 12 years of age has been reduced at least 40 per cent. It seems unfortunate, therefore, that only 31 towns and cities in North Carolina and less than 800,000 of its population are fluoridating their water supplies, even though the North Carolina Dental Society, the Medical Society of the State of North Carolina, and similar medical, dental and public health national organizations have endorsed fluoridation as being safe and beneficial in the lessening of dental caries.

b. The 45 orthopedic clinics of the Crippled Children's Section experienced a gradual increase in the patient load of each program. There was also a continual patient increase in the seven rheumatic fever and four speech and hearing clinics. Even though this Section has suffered the loss of a nurse consultant in Child Growth and Development, one additional speech and hearing clinic has been opened this year.

9. The Sanitary Engineering Division made a complete sanitary survey of jails and city lock-ups, and assisted the Prison Department in the inspection of highway prison camps. Sanitary inspection of nursing homes and homes for the aged continued unabated. Many of the conventional sanitation activities were expanded because of population growth and industrial development. Food-handling regulations were revised to include sanitation standards for outdoor dining areas, and during the year special attention was given to water and sewage disposal problems in the coastal counties.

10. The Laboratory Division is an institution within itself, and one which has rendered faithful, conscientious and competent service to the people of this State since its first director began work in 1908. There were no changes in 1959 except in additional examinations. Your Laboratory Division is continually reviewing and evaluating its program and looking for new methods and laboratory techniques to better serve the people of North Carolina, within the structure of the State Board of Health.

The Laboratory Director, Dr. John H. Hamilton, resigned April 30 after serving

the state faithfully and competently for 40 years—the first 11 in New Hanover County. His dedication to the field of public health has been for the citizens of North Carolina a providential blessing beyond the realm of tangible values. Testimonials and expressions of appreciation for his services are to be given at a later date under more appropriate circumstances. It suffices here to say that the Laboratory Division will always be, to those of us who are fortunate enough to have known Dr. Hamilton, a symbol of unselfish service and a monument to his memory.

The work and service of many other Divisions and Sections within the State Board of Health deserve commendation and should be mentioned but time does not permit.

11. I would be derelict in my duty toward you on behalf of my colleagues who serve on the State Board of Health, if I failed to mention the excellent administration of the State Board of Health under Dr. J. W. Roy Norton. It is almost inconceivable that Dr. Norton can perform his executive and administrative duties and also engage in the many activities that involve public relations on behalf of the State Board of Health and the Medical Society of the State of North Carolina. In order for North Carolina to maintain its commendable health position, it is necessary for the State Health Director to keep abreast of the developments in the field of health affairs, through the state and over the nation. He does this through wide professional reading, attendance at regional, national and international conferences, and frequent visits to various sections of North Carolina. By such visits and through such professional contacts, the State Health Director is able to keep in close touch with industrial and agricultural development, and to identify the approaching public health needs and promote measures for meeting those needs.

12. Other activities of the State Board of Health are continuing unabated through the various Divisions and Sections, and through our chief aim of service—the local health departments serving all one hundred counties. The enlargement of programs to deal with chronic diseases and care for the aging tops the list of North Carolina's public health needs for the year ahead.

Conclusion

Perhaps there remain in the minds of some the editorial ideas expressed in the beginning. If so, this brief and partial summary of the activities of public health work in North Carolina has been of value only insofar as it has fulfilled the requirements of law. If it has given to some a better un-

derstanding of the inner workings of the State Board of Health and local health departments, and if it serves as a basis for a more understanding attitude toward the local health departments and the State Board of Health, our time will not have been spent in vain and this report will have served its intended purpose.

Treatment of Pulmonary Emphysema

PHILLIP E. RUSSELL, M.D. ASHEVILLE

Emphysema is a common disease. Our population is growing older; smoking is becoming more widespread; and we are keeping alive patients with asthma, pneumonia, and chronic bronchitis. As a result we shall inevitably see more and more emphysema; so the treatment of this disease is becoming increasingly important. This discussion is concerned primarily with the long-term care of outpatients with chronic, diffuse, obstructive, pulmonary emphysema. I shall not attempt to include the problems which arise in the hospital treatment of the acute respiratory crisis.

In the patient's history it is noted that he has had repeated hospital admissions; and although he is said to be improved after each admission, we know he is becoming progressively worse. Can these admissions be prevented? Can the course of this disease be changed? Yes! Emphysema can be diagnosed early and the progression of the disease can usually be halted.

We are slowly gaining some understandof the etiology and the usual course of the
disease⁽¹⁾. More people are coming to the
doctor for routine checks; therefore, we
have the opportunity to suspect this disease
early, at a time when we can really do
something about it. Also, the increasing
office use of pulmonary function tests such
as timed vital capacities and maximum
breathing capacities is giving us a means
of confirming our diagnoses and of following the course of this disease⁽²⁾.

The treatment of emphysema might be divided under three headings: psychic, medical, and physical.

Psychotherapy

Psychotherapy should be considered first because it is the most important in the long term care of these patients. It is strange that little has been written about the psychic aspects of emphysema when one considers how closely it is related to asthma and how frequently the two diseases overlap. It would be difficult to find a paper on asthma in which the psychic factors are not mentioned. In emphysema, however, one can see organic changes at the autopsy table and under the microscope; so it is usually considered purely an organic disease. No one can treat many of these patients without realizing the importance of psychic factors. Breathing itself is closely emotional responses (3). associated with Emotional upsets are reflected in increased tidal volume and thus in increased air trapping in the emphysematous patient. Constant smothering as a threat to survival creates emotional problems if they were not already present. These patients become demanding, impatient and intolerant, and are continually looking for some easy cure. When they are slightly improved or helped over a crisis, they are satisfied and discontinue all therapy. They beg for help one minute and say they will do anything, then break the next appointment or flatly refuse to give up smoking.

For good results one must take time with the patient, explaining over and over the nature of the disease, its seriousness, and the importance of treatment. He needs help in adjusting to the disease and help with emotional problems which arise. Certainly, the chief cause for failure in the long-term treatment of emphysema is not the use of

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the wrong drug but the failure to obtain the full cooperation of the patient.

In evaluating other therapy, psychic factors are important. It is interesting to watch a group of old wheezers on a ward where there are rotating residents. On the first of the month, they will be smiling and breathing easily. One of them will say, "That doc really knows his business; he started me on some new medicine and I believe it's going to fix me up." A review of the chart shows that the new resident has substituted one ephedrine compound for another, but he also has shown some interest and optimism. By the end of the month, however, the resident is discouraged and the wheezers are again gasping for breath and wanting more intravenous aminophylline. In spite of this observation, many papers on the treatment of emphysema have inadequate controls and no long term follow-up. Since the results with various programs of treatment are similar, one wonders if psychic factors caused the improvement. Give one of these patients a new prescription and he will feel better before he leaves the office. Therefore don't prescribe all the useful drugs at once: Give them one at a time, so when a patient starts to become discouraged, you can give him a new medicine.

Medical Treatment

Medical treatment is usually vigorously prescribed. Many patients have already tried most of the drugs used for emphysema when they are first seen, and they even have strong ideas about which medicines are most effective. Most physicians are familiar with the various drugs used; so I shall not try to cover medical therapy completely, but I would like to make a few comments. Epinephrine, isuprel, ephedrine, aminophylline, and potassium iodide are still basic treatment for wheezing [4]. There are some interesting arguments about mechanisms of action, but empirically these drugs work as well as any we have.

Antibiotics are of great value⁽⁵⁾. They literally keep these people alive, since emphysema is characterized by recurrent bacterial infections which are life-threatening. The appearance and quantity of the sputum is a good indication of when antibiotics are needed. It is helpful to have the patient bring in a 24-hour collection of sputum on each office visit, because relying on his own

description of his sputum can be misleading. Occasionally gram strained smears or cultures and sensitivity studies are helpful in choosing the best antibiotic. The prophylactic or long-term use of antibiotics is a controversial subject. Although some well controlled reports are favorable, antibiotics are not widely used prophylactically because of general principles and because of accumulating proof that in other situations they are not helpful and are perhaps harmful. Prompt use of antibiotics for acute flare-ups of infection is as good or better than prophylactic antibiotics, and is safer and cheaper.

The patient should be considered from the standpoint of allergy. A search for allergens should be made. He should sleep in a bare room and all directly irritating substances should be avoided. One important offender is tobacco smoke. Recent papers have shown that most emphysematous patients smoke considerably more than control patients, all smokers have comparatively reduced maximum expiratory flow rates, and most smokers have a chronic cough. Clinically, it is certainly important for the patient to stop smoking. On the other hand, it is surprising how many of these patients have been told this many times without stopping, and no matter how much one explains and begs, they continue smoking. Certainly, to get the patient to stop smoking is a real test of a good doctor-patient relationship.

Sometimes when there are definite signs that allergic factors are important, the patient should be studied by an allergist with skin tests and the whole allergy regimen.

Finally, when all other medical treatment fails, steroids can effect dramatic results. Any patient who has crippling pulmonary emphysema deserves a trial on steroids^(6,7).

Physical Treatment

Physical treatment comes last, but it is not the least important in the long-term treatment of these patients^(N). While medical treatment is vigorously prescribed, physical treatment is largely neglected. Some physical measures are necessary for good long-term results. Postural drainage is of primary importance^(N). Anyone with enough sputum or cough to need an expectorant needs postural drainage. These patients are never too sick for postural drainage, but they do become too sick to do with-

out it. Putting a patient on his side with a pillow under his waist and having him breathe deeply while raising his arm is a reasonably effective method, and is easy enough for the patients to continue doing it. Lying on a bed with the head lowered 20 degrees helps drainage, especially if the patient has been carefully instructed in abdominal breathing. An occasional patient with a large volume of sputum needs to use other positions for drainage, and he usually discovers which position is most productive. However, he will not find out unless he is shown the various positions. If a patient who has a considerable amount of sputum is given no medicine but only shown postural drainage when first seen, he is less likely to give medicine credit for his improvement. It is striking how much some patients improve on adequate drainage alone.

Some patients with an irritating non-productive cough need to be taught how to cough. It is helpful for them to exhale about half a breath, then cough, because this makes the cough less irritating, does not over inflate the chest, and is actually more productive in emphysematous patients⁽⁸⁾.

Breathing exercises and re-education in breathing are helpful over the long term(5). Sessions may be started with instructions in how to relax. The patient is put on an examining table with his head lowered about 20 degrees. The mechanics of breathing are explained, and he is taught to use more abdominal breathing and less chest breathing. Pursed lip breathing is taught; exercises are given to loosen up rib cages and strengthen abdominal muscles. Some patients are helped by teaching them to put force in exhalation rather than inhalation. Also, interrupted expirations are helpful. For example, the patient makes short repeated forceful expirations until his chest is as empty as possible of air, or he can say "P" or "F" over and over. These procedures promote drainage, strengthen expiratory muscles, and get rid of trapped air. They can be done anywhere or anytime and are particularly effective just before some necessary exercise. Nothing can be achieved in two or three visits, but with patience and persistence the patients are helped greatly.

Physiotherapy must be used along with the medical measures. Part of the benefit, I suspect, is psychic, because it gives the patient something he can do, puts some of the responsibility for treatment upon him, and gives him some hope and encouragement, which are extremely important. The instructions make him feel that the doctor is interested in him. Moreover, when a crisis comes, he is more confident that he can control his breathing, and thus is less terrified.

Conclusion

To obtain maximum results in treating a patient with obstructive pulmonary emphysema, we must diagnose the disease early, then carefully evaluate our patient. We must tailor the treatment to suit the individual patient, using every means at our disposal. We must treat him psychologically, medically, and physically. If carefully treated, most of these patients can be maintained indefinitely in reasonably good health.

References

- McLean, K. H.: The Pathogenesis of Pulmonary Emphysema, Am. J. Med. 25:63-74 (July) 1958.
- Armstrong, B. W.: Clinical Pulmonary Function Testing. Ann. Int. Med. 51:405-412 (Aug.) 1959.
- Hammarsten, J. F., and Wolf, S.: The Role of the Emotions in Respiratory Disease, M. Clin. North America 43:113-126 (Jan.) 1959.
- Farber, S. M., and Wilson, R. H. L.: The Rational Approach in the Use of Bronchodilators in Chronic Respiratory Disease Ann. Int. Med. 50:1241-1251 (May) 1959.
- Barach, A. L.: Pulmonary Emphysema, Baltimore, The Williams & Wilkins Co. 1956, p. 321., 118.
- Warren, J. M., and Cameron, L. M.: A Study of Prednisone Therapy for Emphysema, Geriatrics 12:653-656 (Nov.) 1967.
- 7. Barach, A.: op. cit, p. 118.
- Miller, W. F.: Physical Therapeptic Measures in the Treatment of Chronic Bronchopulmonary Disorders; Methods for Breathing Training, Am. J. Med. 24:929-940 (June) 1968.

Trimeprazine (Temaril) as an Antiemetic And Antitussive in Children

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RALEIGH

Clinical studies⁽¹⁾ of trimeprazine have concentrated on assessing the drug as an antipruritic agent, although studies in animals⁽²⁾ show that it possesses antiemetic properties, and Green^(1e), in his study, observed antitussive effects in a few patients with cough who were given the drug to control itching. The present study was undertaken to determine clinically whether trimeprazine controls vomiting, and to explore further its antitussive effects.

Antiemetic Series

Forty-eight infants and children with vomiting secondary to acute infectious states, chiefly viral gastroenteritis and pharyngitis, and 2 infants with vomiting due to pylorospasm were given trimeprazine. In these 26 girls and 24 boys, who ranged in age from 2 months to 9 years, treatment was started approximately 4 to 12 hours after the onset of forceful vomiting and of repeated episodes of retching. Other clinical manifestations included fever, abdominal cramps, malaise, diarrhea, and restlessness. Signs of dehydration were not pronounced, although mild acidosis was present in 2 children.

Children weighing up to 30 pounds were given 1₂ teaspoonful of trimeprazine syrup, three to four times daily; those weighing over 30 pounds were given 1 teaspoonful, three to four times daily. Each teaspoonful contained 2.5 mg. of trimeprazine.

Parents were asked to offer fluids approximately one-half hour after they gave the child the first dose of trimeprazine and to note whether the fluids were accepted and retained. The 14 children who had pharyngitis and otitis media, with or without gastroenteritis, were given one 2 cc. dose of long-acting Bicillin intramuscularly, along with trimeprazine orally. Once they were able to retain fluids orally, they were started on Madribon Suspension while continuing trimeprazine.

Antitussive Series

Twenty-eight children with persistent cough associated with recurrent attacks of

acute pharyngitis, tonsilitis, and bronchitis comprised the study group. All but 3 of these 10 girls and 18 boys were 5 years of age or younger; 5 were less than 1 year old. Since these children had fever and nasal congestion in addition to cough, they were given a modified formulation of trimeprazine syrup to which an antipyretic (acetaminophen) and decongestant (phenylpropanolamine) had been added. Other symptoms present included headache, sore throat, muscle aches, and occasional vomiting. The usual dosage was 12 to 1 teaspoonful, 3 or four times a day, depending on body weight. Each teaspoonful supplied 2 mg. of trimeprazine, 120 mg. of acetaminophen, and 10 mg. of phenylpropanolamine. All but 2 of the children were given one 2 cc. dose of long acting Bicillin intramuscularly and subsequently maintained on Madribon Suspension to treat associated bacterial complications.

A check was made two days later to inquire about the patient's cough and general condition. Any decrease in cough which occurred quickly—that is, within 4 to 12 hours—would more likely be due to antitussive than antibacterial activity.

Results

Trimeprazine appeared to be very effective for controlling vomiting associated with acute gastroenteritis. Except for the 2 patients with pylorospasm and 1 with gastroenteritis, none of the children experienced any further vomiting after they took the drug. Parents noted that the children were able to take and retain clear liquids and soft foods within two hours following the administration of trimeprazine; most were able to take liquids within 30 minutes. Those with bacterial infections experienced no return of vomiting when they started taking the sulfonamide preparation orally, and rehydration was accomplished without resorting to parenteral fluids, even in the 2 who were acidotic. The exceptions who obtained no relief with trimeprazine later benefited from other types of treatment.

The 2 infants with pylorospasm responded to combined pentobarbital and homatropine methylbromide. These failures indicated that trimeprazine lacks the parasympatholytic activity of belladonna derivatives, and in all likelihood mainly acts centrally, like other phenothiazine antiemetic agents, on the emetic chemoreceptor trigger zone. One child with vomiting due to gastroenteritis was unable to keep trimeprazine down long enough to benefit from it until she was given a paregoric enema. After that, she had waves of nausea but no further vomiting.

Almost all the parents continued giving trimeprazine for an additional day or two after the cessation of vomiting, to help prevent a recurrence. Some thought that the children seemed to be calmed when taking trimeprazine and were more amenable to bed rest. Whether these effects were due to the drug or merely coincidental with the disease is difficult to determine with certainty. In any event, none became more restless or irritable, or suffered loss of coordination, as sometimes happens with barbiturates.

Trimaprazine also proved to be a useful antitussive agent. In 20 of 28 children given the modified formulation, relief of cough was judged by parents to be satisfactory. Several with croup and wheezing due to bronchial asthma experienced a considerable reduction of nighttime distress. Results were also particularly good in a very difficult allergic patient with chronic cough and wheezing due to asthmatic bronchitis. In 4 children, however, no reduction of cough occurred until after their pharyngitis and bronchitis were brought under

control with antibacterial therapy. In the remaining 4 children, results were judged to be partly satisfactory—or perhaps simply uncertain—since cough was controlled at night but not during the day. The decongestive and analgesic effects of the formulation further helped ease discomfort.

It may be interesting that of the 20 children who obtained satisfactory relief from coughing, 13 experienced moderate sedation, whereas only 3 of 8 with an unsatisfactory or uncertain response did. The sedative effect was more calmative than soporific. During the day it showed itself in reduction of irritability or restlessness; at night, in helping them fall asleep readily.

Summary

A clinical trial of the antipruritic, trime-prazine, in 78 infants and children showed that the drug also has clinically useful antiemetic, antitussive, and sedative properties. It controlled vomiting and retching associated with acute infectious states, especially viral gastroenteritis, but failed to arrest vomiting due to pylorospasm. As adjunctive therapy in acute respiratory infections, a modified formulation relieved persistent cough and reduced irritability in children with acute pharyngitis, tonsilitis, and bronchitis. No side effects of consequence occurred with its use.

References

- (a) Callaway, J. L., and Olansky, S.: Trimeprazine: An Adjuvant in the Management of Itching Dermatoses. North Carolina M. J. 18:320-321 (Aug.) 1957. (b) Williams, P. L.: A New Oral Antipruritic, Northwest Med. 57:1162-1164 (Sept.) 1958. (c) Green, M.: Clinical Evaluation of a Unique Anti-Allergic Drug—Trimeprazine, Ann. Allergy 16:619 (Nov.-Dec.) 1958.
- 'Temaril' Investigational Circular, Research and Development Division, Smith Kline & French Laboratories, Philadelphia, Pennsylvania., August, 1958.

Before prescribing a preparation each physician should make use of the simple guides and ascertain if his knowledge and the merits of the proposed agent are such as to warrant its use. Furthermore, in these days of ever-increasing costs no drug preparation should be prescribed until the physician has some idea of the cost. Frequently, much less expensive and as good or nearly as good alternate agents are available if the physician informs himself about cost and devotes sufficient time to drugs and their uses so that he can wisely select alternate preparations.—Friend, D. G.: Polypharmacy—Multiple-Ingredient and Shotgun Prescriptions, New England J. Med. 260:1017 (May 14) 1959.

Short-Term Group Therapy With Hospitalized Non-Psychotic Patients

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This paper describes two years of experience in group therapy on an 18-bed open psychiatric ward of the University of North Carolina Medical School. The experience is reported because it has been found to be of clinical value and because it illustrates certain points of group therapy. Meetings lasting from one-half to one hour were held from one to four times per week; average attendance was from 6 to 12 patients, and the average patient stay was between three and four weeks. Each patient also received at least four hours per week of individual psychotherapy from one of several psychiatric residents or psy-These same physicians, and chiatrists. others, acted as group leaders. Previously a different method of combining group and individual therapy had been used, one in which therapists treated their own patients in group and individual sessions(1).

A. Population

The population of the ward was predominantly non-psychotic and female. During the day the patients were also attended by medical students, nurses, student nurses, aides, occupational therapists, recreational directors, and social workers. Group therapy was utilized for its unique values rather than as a way to keep the patients occupied or as a substitute for individual treatment. All patients except children and those grossly confused were invited to attend, and most of them did. Adolescents commonly refused to come, and severely depressed patients attended but did not verbally participate.

B. Method

Several measures were designed to facilitate group progress. Most, but not all of the meetings were preceded by a motion picture illustrating psychodynamic points. The patients were told they could discuss the picture or not as they chose. The films were utilized to introduce significant con-

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tent and to provide a common point of departure for group meetings.

The therapist was told not to give advice or to encourage discussion of symptoms. He was to encourage discussion of feelings about contemporary figures including friends, relatives, hospital staff, and each other. Group reactions to the leader and reactions within the group were clarified; individual reactions to the leader seldom were.

There were also some policies designed to limit the scope of group therapy. Discussion of feelings directed toward past figures was permitted but not encouraged. Dream material and free association were not requested. Most important, patients were permitted to discuss feelings toward their individual therapists, but always with the suggestion that they bring up this material in individual treatment sessions. This policy, while regrettable in terms of group therapy, was necessary because a primary function of the ward was training in individual psychotherapy, and it was felt that this should be minimally complicated.

C. Group Process

The recurrence of situations and sequences of situations in this experience is significant. While the turnover of patients was continuous, it was uneven. The departure of a group of patients, or even of a key patient in the group, led to "starting over." A heavy influx of new patients often had the same effect. Frequently occurring situations will be discussed in terms of objective phenomena and group process in the sequence in which they occurred.

1. The "classroom"

The members treated the meeting as a course on how to rear children and the leader as a teacher. This attitude was thought to be the result of the use of motion pictures stressing childhood problems, as this material was too remote to be dealt with directly and thus lead to detached discussions. Films dealing with adult

problems were obtained, but the only change was that in this phase, when the new motion pictures were shown, sessions became classes on marriage or how to act at work, and the leader was still treated as a teacher. In this phase the members have no concept of how to operate as a therapeutic group, and the "classroom" phenomenon occurs as the group, wanting to be passive, places responsibility on the leader (2). This situation recurs despite efforts to do away with it.

2. Bored discomfort; hostile silence

This phenomenon occurs spontaneously when the group sees little point in the classroom approach or comes about when the leader interprets the existence of that situation. The members are silent and unhappy. The therapist has to restrain himself from prematurely ending the meeting.

The group is united by being in the hospital, and, in most cases, by the hostile component of ambivalent feelings concerning dependence. There is not sufficient group identification to give the support needed to express anger; anger is acted out by group passive-aggressive techniques. Therapists and observers can feel the tension and hostility.

3. Overt anger directed outside the group

The members complain of their doctors, nurses, food, ward rules and policies, wives, and husbands. They do not criticize each other or the leader, although they may castigate absent members. This spontaneously follows the hostile silence or can usually be produced by the therapist's interpreting the silence as hostility. At this point there is sufficient group feeling to make the voicing of anger acceptable; the expression solidifies the group.

Here again efforts were made to alter the development of the group. An additional meeting devoted to discussing ward problems was introduced, but this had no effect on the group. If administrative meetings were held when the group was angry, everything was criticized; but criticism continued during therapy meetings. Administrative meetings held when the group was more friendly were quiet and pleasant. The periodic emergence of anger cannot be controlled by changing the ward situation.

4. Overt anger directed toward a member

Overt anger usually occurs spontaneously and creates problems in meetings and on the ward. The behavior of the victim generally more than justifies the hostility expressed. Unfortunately the patient involved is usually ill equipped to tolerate the situation, and therefore the leader must try to support him. The group lives together all day, and the hostility may not end with the meeting. If the victim becomes more ill, the others feel guilty and the group regresses to bored silence. Often the victim stops attending or is silent during future meetings. Fortunately the victim is also receiving individual psychotherapy, and the individual therapist can help him.

This is a "scapegoat" phenomenon. The group has further solidified by directing intra-group hostility toward one member.

5. Overt hostility directed toward the leader

Eventually or alternatively the hostility may be directed toward the therapist. The complaint is that he does not tell the members what to do. Such phrases as "He doesn't know, either," or "What's the use?" are in evidence. The group may regress to bored silence.

The situation is one of open group hostility to the leader as a result of frustrated dependency needs⁽³⁾. The "orality titer" is particularly high in inpatients, and the process is intense. Despite group support guilt is still associated with this behavior.

The hostile phase resolves itself when the group realizes the reason for its anger. This may occur to the members or be permissively interpreted by the therapist. If the interpretation is successful, the group realizes and accepts that it is useful to express and try to understand feelings.

6. "Group therapy"

Feelings—usually anger, sometimes affection, rarely sex—are expressed and an effort is made to understand them.

It is here that the inhibiting factors discussed previously come into play. Techniques that would promote insight and uncovering, such as discussion of dream material and the encouragement of the degree of free association possible in a group, are usually avoided. Occasionally, however, therapists break the rules. If utilized, these methods are effective.

Another limit on group therapy is the referral of feelings pertaining to individual therapy back to the latter situation. thus permitting but discouraging the expression of some usually interested affects. When the group is functioning well, therapists have fantasies of discharging the members in toto and continuing with it in outpatient therapy. Then, as a result of therapy or coincidence, the better patients go home or there is an influx of new patients. The situation regresses to the "classroom." Patients left over from the last cycle complain wistfully that the meetings used to be different; so does the therapist, but to himself.

D. Factors Influencing Group Progress

- 1. Frequency of meetings: Experience is that the sessions are more comfortable and group progress is more rapid if meetings are held three times per week. If held less frequently they lack continuity: if held more frequently the group stagnates at the phase of bored hostility. This probably occurs when feelings involved in the group situation become too intense.
- 2. Use of motion pictures: Presentation of films gives the group, including new members, a common starting point for each session. Progress is more rapid, however, if one meeting per week is held without the preliminary motion picture, as the group thus has a little more freedom. During one phase of excellent function the group and the therapist decided to dispense completely with the motion pictures and the group subsequently collapsed. The motion picture obviously has some supportive and unifying value in a group as transient as the ward population.
- 3. Therapist: Some therapists are more successful than others, but experiences are essentially similar. At one time all three residents assigned to the ward took one meeting per week, and there was no progress. The group functions best under one therapist and routinely regresses with a change,
- 4. Patients: The following observations are based on clinical impression rather than systomatic analysis of data. The group progresses best when at least half the patients are between 20 and 40 years of age. A group in which the active members are all of the same sex or evenly divided pro-

gresses best. A group with six active women and one man bogs down.

Depressed members do not generally participate verbally, but if the group is going well they seem to derive considerable benefit. These patients are often silent but pleased when others express anger. Borderline schizophrenic patients are quite active at meetings and derive support from the group and further group progress. An admixture of patients with hysterical and obsessive character structures does well, but so does a group of those with hysteria; a group of obsessive patients alone or with one hysteric patient is unsuccessful.

E. Effects of the Program

- 1. Individual therapists note that their patients have a surprising intellectual awareness of the effects of childhood experience and of the unconscious. This factor generally expedites individual therapy. Sometimes, with obsessive-compulsive patients, this awareness leads to prolonged intellectualization in individual psychotherapy, but the same phenomenon usually occurs in any event with these patients.
- 2. Individual therapists note that some of their patients become much freer in expressing feelings. The support given by the group seems to explain this: often the patient states that he learned in the group that "everyone feels that way."
- 3. This program does not interfere with individual psychotherapy. The techniques used prevent working one situation against the other and leave large areas of support and interpretation solely to the individual therapist. Material from the group often comes up in individual treatment, but the reverse is seldom true⁽⁴⁾.
- 4. The staff notes a greater cohesiveness on the part of the patient group. Although patients will interact in any circumstances the quality of interaction is subject to change. When the group is in its more advanced phases, the patients are more aware of each other as people and are thus more interested, sensitive, and considerate.
- 5. The reports of the group therapist make the individual therapists more aware of the patients as people.
- 6. Since this is commonly their first group experience, the resident physicians involved usually become interested in group therapy early in training.

Summary

The utilization of group therapy with a changing population of hospitalized psychiatric patients has been described. Methods of having the group supplement rather than duplicate or compete with individual psychotherapy, stages of group development, factors influencing group progress, and results of the program are discussed.

References

- Frank, J. D., and others: Behavior Patterns in Early Meetings of Therapeutic Groups, Am. J. Psychiat, 108:771-778 (April) 1952.
- Fried, E.: The Effect of Combined Therapy on its Productivity of Patients, Internat. J. Group Psychotherapy 5:3255, 1954.
- Harper, R.: Concomitant Individual and Group Psychotherapy. North Carolina M. J. 18:545-548 (Dec.) 1957.
- Osberry, W., and Berliner, A. K.: The Developmental Stages on Group Psychotherapy With Hospitalized Narcotic Addicts, Internat. J. Group Psychotherapy 4:436-446. 1956.

 Powdermaker, F. B., and Frank, J. D.: Group Psychotherapy, Cambridge, Massachusetts, Harvard University Press, 1953.

Appendix Motion Pictures Utilized

- Anger at Work. Internat'l Film Bureau, Inc., 57 E. Jackson Boulevard, Chicago 4, Ill.
- Emotional Health. McGraw Hill Bk. Co., Text-Film Department, 330 W. 42nd St., New York 36, N. Y.
- Feelings of Dependency. National Film Board, Suite 658, 630 5th Ave., New York 20, N. Y.
- 4. Feelings of Hostility. Nat'l. Film Brd., Suite 658, 630 5th Ave., New York 20, N. Y.
- Feelings of Rejection. McGraw Hill Bk. Co., Text-Film Dept., 330 W. 42nd St., New York 36, N. Y.
- 6. Meeting the Emotional Needs of Childhood. New York University Film Library, Press Annex Bldg., 26 Washington Pl., N. Y. 3, N. Y.
- Preface to Life. Castle Films, 1445 Park Ave., N. Y. 22, N. Y.

The Anterior Tibial Syndrome

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The term "syndrome" attached to a clinical entity connotes a certain lack of knowledge. Such is the case of the anterior tibial syndrome. As recently as 1942 Childs reported the first cases, while even now many mild cases pass unrecognized, owing in part to unfamiliarity with the problem. An inherent lack of knowledge of vascular problems of the lower extremities on the part of orthopedic surgeons has slowed investigation concerning the etiology. Since exercise, pain, or an intermittent claudication are present in all cases, treatment is directed toward improving the physiology of circulation and muscle metabolism.

Anatomy

The anterior tibial compartment is contained rather rigidly by a fascial envelope anteriorly, the tibia and fibula on each side, and a heavy interosseous membrane posteriorly. The major entrance and exit of circulation is at the superior margin of the interosseous membrane through the perforating anterior tibial artery and veins. The deep peroneal nerve looping around the neck of the fibula provides innervation for the anterior tibial, extensor hallucis longus, extensor digitorum longus, and peroneus tertius muscles. The transverse crural ligament overlying the artery, veins, nerve, and tendons creates a bottleneck distally.

In the anterior tibial syndrome, pain or a sense of spasm on exercise are always present. The pain is described as radiating bilaterally over the anterior aspect of the leg from the knee to the ankle. It is relieved by short periods of rest. Pulsations to the feet are usually strong, and there is no loss of hair or skin manifestations of peripheral vascular insufficiency. The development of muscle groups in the quadriceps, calf, and anterior compartment are well delineated. Case reports often reveal cases in athletes, foot soldiers, and other individuals engaged in vigorous endeavor.

Treatment

The problem of relief of pain on exercise, therefore, is a change of activity or surgery. Mavor⁽²⁾ reports the relief of symptoms in a football player by decompression of the anterior tibial compartment using a fascial graft. This restored the athlete to full activity, free of pain.

Case Report

A 34 year old mailman was examined because of pain in both legs from the knee to the ankle. He had noticed a sensation of hardness in the anterior compartment for several years, but with the recent addition of a mile of hilly terrain to his daily 12-mile route, the pain prompted examination.

After four hours of walking, he would note the development of hardness in the muscles. A five-minute rest would permit further walking, with only a few stops during the remainder of his six-hour jaunt. Examination of the patient revealed a slightly overweight, well muscled individual. Well developed muscle groups were noted. Hair distribution on the legs was normal. Good femoral, dorsalis pedis, and posterior tibial pulsations were present, and motor power was found to be normal. Arteriography was not performed.

I suggested that while I investigated the literature pertaining to the anterior tibial syndrome, the patient abstain from smoking, which he managed to do for four days. This did not alter the picture. A cut-back on the mail route was then suggested. Seven months later the patient still notices a hardness developing after four hours of walking. After five-minute rests he continues. His route has been shortened one mile of the particularly hilly terrain, enabling him to remain on the job.

Comment

A chronic form of anterior tibial syndrome is stated by Howard to be peritendinitis crepitans. Pearson, Adams and Denny-Brown⁽³⁾ report "shin splints" as being still a milder form of the entire problem of muscle ischemia involving the anterior tibial compartment. With the increase of muscle volume associated with exercise in a tight compartment, the veins are the most vulnerable to compression.

The effect of venous obstruction early in a Volkmann's ischemia is associated with local congestion or lessening of the circulation. It is felt that the anterior tibial syndrome is comparable to the localized ischemic contracture in the hand described by Bunnell'. Fibrosis of the muscles of the anterior compartment can result in advanced cases, as reported by Phalen'5. The advanced cases are usually preceded by major injuries of this region, such as a fracture of the tibia and fibula. From the athlete, mailman, or soldier, fibrosis would not be anticipated in the unadulterated tibial compartment.

Summary

- 1. A review of anatomy, symptoms and treatment is presented.
- 2. For illustration a case report is reviewed.
- 3. Proposed similarity to localized Volkmann's ischemia is discussed.

References

- Childs, C. G.: Noninfective Gangrene Following Fractures of the Lower Leg. Ann. Surg., 116:721-728 (Nov.) 1942.
- Mayor, G. E.: The Anterior Tihial Syndrome, J. Bone & Joint Surg. 38-B, 513-517 (May) 1956.
- Pearson, C., Adams, R. D., and Denny-Brown, D.: Traumatic Necrosis of Pretibial Muscles, New England J. Med. 239:213-217 (Aug. 5) 1948.
- Bunnell, S.: Ischaemic Contracture, Local, in the Hand;
 J. Bone & Joint Surg. 35-A; 88-101 (Jan.) 1953.
- Phalen, G. S.: Ischemic Necrosis of the Anterior Crural Muscles; Ann. Surg. 127:112-120 (Jan.) 1948.

The wisest plan conceived by the consultant and the family doctor will miscarry if it has not the fullest accord of the marital partner. An over-protective spouse, who continuously dissuades her husband from putting his hands to any kind of work, has often wrecked the considered advice of a physician, and for this reason it might be more important to treat her than the patient. On the other hand, the wife of one who has passed through an attack of cardiac infarction can be a powerful ally to a doctor in his struggle to restore the patient's self-reliance, and her services should be enlisted at the start.—Evans, W.: Faults in Diagnosis and Management of Cardiac Pain, Brit. M.J. 1:252 (Jan. 31) 1959.

Progressive Patient Care

ROBERT R. CADMUS, M.D.

CHAPEL HILL

A recent issue of *Life* magazine contains a two-page advertisement concerning hospital administration. It describes hospitals as "fast-paced and complex." Yet in spite of this complexity, hospitals, with rare exceptions, have served patients well.

As you know, hospitals have been in existence a long time. They probably antedate recorded history, but they certainly existed in early China, Egypt, the Roman and the Grecian Empires, and down through the ages to the present day. But the social institution which we call the modern hospital is really a creature of our own century, during which we have witnessed the miraculous advent of the biological sciences. After all, Roentgen, the discoverer of x-rays, was still living when l was in high school, and the lives of such notables as Koch, Pasteur, and Lister crossed the span of years of many living today. During this slow evolutionary process hospitals learned to "roll with the punches." Roentgen's magical rays now come from machines priced at \$25,000. We have conquered, and almost lost again, our war against some of Lister's bacteria, particularly the resilient staphylococcus. We have all but conquered Koch's tubercle bacillus. We have even learned to enjoy the 40-hour week and the fringe benefits of industry, and we have reluctantly surrendered to the coffee break.

But we have also learned to rethink our patterns of patient care in order to improve our services and keep our costs within the people's capacity to pay. Some of this rethinking has been appropriately termed "progressive patient care."

Definition

Now the word "progressive" is a bit of a pun. In one sense it means "marching on," as one progresses from infancy to the "added years" about which this conference is concerned. Of course the other meaning of the word "progressive" is "forward-looking." It connotes leadership. Actually, "progressive patient care" has much of

Read before the National Conference on Aging, American Medical Association, Atlanta, Georgia, March 8, 1960. both meanings. Patients are moved from one unit of the hospital to another as their conditions change, and in this way they progress. I do not want, however, to give the false impression that this is any Hollywood freeway. Most patients are assigned to and are discharged from a single unit, but since they receive care that is tailored to their particular needs, they at least experience care under the other meaning of "progressive."

By definition, progressive patient care means the organization of facilities, services, and staff around the medical needs of the patient. Obviously, this definition encompasses the newborns as well as the oldsters. According to recent Health Information Foundation statistics, the two groups at the end of the age scale—that is, children under 6 years of age and persons over 65-increased their use of medical services by about 45 per cent during the past five years. Consequently, this concept is of pointed concern to the oldsters, since they need the full range of progressive patient care even more than does the youngster. This is why the subject of progressive patient care logically comes up at this conference. It is designed, in great measure, with the older patient in mind, and should be considered in your total planning.

Types of Facilities

The progression of services under the concept of progressive patient care involves five types of facilities. These elements, with additional study and experimentation, may conceivably be expanded or contracted, but at the moment the five satisfactorily cover the full range of the familiar spectrum of health facilities.

The first facility, Intensive Care, is designed to concentrate the critically and seriously ill patients within a single hospital unit — regardless of diagnosis — in order to provide maximum professional attention. (2) Intermediate Care concentrates patients who require a moderate amount of routine nursing care, but who do not present an emergency. (3) Longterm Care concentrates patients requiring

prolonged but also skilled medical and nursing services for diagnosis or treatment. (4) Self Care concerns patients who are relatively self-sufficient, but who still require certain specialized services not available in the ordinary home or community environment. (5) Organized Home Care extends hospital-type services into the home, so that none of the advantages of institutional care are lost in a domestic setting.

Intensive care

Let us now develop each of these elements in more detail and try to relate them to the problems of the older citizen. Analysis of the patient population in any hospital reveals a small percentage—in our institution it is about 11 per cent-who require constant medical supervision, a high degree of nursing skill, an inordinate amount of complex and expensive equipment, and voluminous expendable supplies. These patients need more than a check every half-hour or every fifteen minutes. or even every five minutes; rather, their every pulse beat and breath should be monitored by nurses within arm's length. patients come to us following heart, lung, or other operations; they come from homes, factories, or highways, with head injuries, overpowering infections, burns, and major internal bleeding; they come from nursing homes or other hospitals, or they may even be transferred to this unit from less critical areas within the hospital itself because of their deteriorating clinical condition. Yet the Intensive Care or Special Care unit, as we like to call it, is a facility to get patients well; it is not one to comfort the incurable. Each patient assigned to this unit is one whom the physician feels may survive with concentrated care, but who might die without it. The type of care has obvious advantages to the oldster who needs every bit of help to tip the balance in his favor.

Intermediate care

The second type of facility is concerned with patients who are less critically or seriously ill, but who still need the skilled medical services usually considered to be routine hospital care. These patients require extensive use of both diagnostic and therapeutic facilities, but in the majority of them survival is not the immediate concern. They represent the typical hospital

patient as we regard him today. In the older patient we may be treating the acute phase of a disease considered to be chronic, or a coincidental illness occurring in the course of some chronic process. An acute episode of decompensation in a cardiac patient is an example of the first, and a neoplasm in an arthritic patient represents the second. This phase is commonly a mere matter of days, but in a few patients it is prolonged and requires rehabilitation. Although we often separate rehabilitation from medical treatment for the sake of emphasis and to capitalize on its public appeal, rehabilitation is only an extension of sound therapy. They are merely different ends of a single spectrum. It is in the Intermediate Care unit that the paraplegic gains back his strength, that the surgical patient heals his wound, and that the battle of infection is finally won.

Long-term care

Next let us consider the Long-term Care unit, in which patients requiring prolonged care are concentrated, and into which some patients from Intermediate Care area will normally move. As we all know, chronic or long-term illness does not necessarily mean complete disability, and therefore we must shade into this area a wide variety of conditions. Yet we must fall back on certain arbitrary definitions or classification of facilities to identify this group of patients. Basically, care of the long-term patient, whether in the hospital or a skilled nursing home, is much the same, and the type of care is amply described in the literature. These patients have some degree of infirmity which requires 24-hour nursing care under medical supervision. They may have suffered a stroke; they may be bed-fast or chair-fast; they may be under a rigid medical regimen or need considerable care in the daily acts of living. Here the slow processes of rehabilitation are further employed in order to regain optimum function in any given situation. We are excluding here those older citizens who need only personal care and homelike services.

Self-care

Next we have the Self-care unit. Here we concentrate ambulatory patients who do not require continuous medical attention or skilled nursing over prolonged periods. Yet this is not merely a motel-type of accommodation. It provides a medical environ-

Home care

ment, complete with diagnosis and therapy, but one in which the patient can contribute to his own care to the best of his ability. We do not include in this category individuals who can be treated in the physician's office or a hospital outpatient department. Here patients live in a relatively normal social environment, go to their therapeutic or diagnostic sessions, receive the indicated care, yet are not confined to bed in the usual "short, split, open-in-the-back jacket."

And finally, since the term "hospital" no longer means merely the four brick walls of a building but rather the organizational structure of a community health center, it is natural that we extend its services into a program of home care. This program enables patients to live at home under the supervision of the medical staff and to receive skilled nursing, social service, physical therapy, homemaking aids, and other ancillary services as needed. Patients are seen on a definite schedule, and their home environment is so altered as to provide maximum medical benefits, on the one hand, and the least dislocation of the family unit, on the other.

I do not want to leave the impression that every hospital must have five separate wings with five neatly printed signs over five doors, each serving a special mission. Rather there is a flow of patients-often in both directions-placing them in the facilities, within or without the building, which will give each the maximum benefit at the least possible cost. Flexibility in placement is not lost; rather it is enhanced.

Problems Calling for Further Study Many features of progressive care, however, are still experimental. One problem which deserves further study is the elderly patient's apparent difficulty in making adjustments, which by the "progressive" nature of this concept he is on occasion required to do. The problem of integrating the educational programs of nurses, medical students, and other health workers into this concept is still unsettled. The real impact upon costs - whether the plan raises, lowers, or has no effect-is another area for study. Will this concept really change hospital design? Do all hospitals need all phases of this program or can good hospitals continue to perform effective community service under more traditional patterns? And finally, will mortality and morbidity statistics really be improved, since no health concept which does not materially register improvement by these yardsticks can be called progressive? Therefore, I must report that progressive patient care is still experimental, but it has made a dramatic entrance and has a potential that is well worth watching.

Even now one may wonder why this presentation was slipped into your program. I hope that it has not only acquainted you with the technicalities and opportunities of progressive patient care, but has also instilled in you an abiding confidence in hospitals. The country over, they are constantly undergoing an agonizing re-appraisal in order to meet the challenge of all age brackets of our expanding nation. I trust that hospital people will be found among the leaders in the search for more adequate treatment for the group in which you are particularly interested today. We in hospitals have "rolled with the punch" in the past; and with your help, understanding, and tolerance we will "roll with the punch" in the future. This dedication will certainly bring progressive patient care to those who have reached the added years.

During the patient's sojourn in the hospital, when he resigns to rest and to soliloquy, the words he hears matter more to him than the dedicated administration of medicine and nursing. In this illness, as in many others, words are more telling than deeds. In this context words are deeds. At this juncture the physician, therefore, should grasp the opportunity to disengage himself from the subdued musing, so much a feature of medical consultations in the ward, to speak purposefully at the head and not at the foot of the sick-bed .- Evans, W .: Faults in Diagnosis and Management of Cardiac Pain, Brit. M.J. 1:252 (Jan. 3) 1959.

Health Insurance and the Practice of Medicine

JACK E. MOHR, M.D.

LUMBERTON

As we have indicated in a previous article(1), voluntary health insurance and the private practice of medicine are necessary to each other. Medicine today can effect cures and prolong life to an extent impossible only a few years ago, but the scientific developments which have made modern care possible have also made it expensive. While this expense is well worth while when lives are at stake, there are few people who can pay for the more expensive medical services out of their own resources at the time the services are received. Hence some method of spreading the costs of medical care, over time and among persons, is imperative. This article will describe the health insurance provided by insurance companies to meet this need and will also discuss some of the ways in which the cooperation of doctors is needed in order that it may fulfill its purpose.

Types of Insurance

Ill health creates many financial needs. It may involve a greater or lesser period without earned income. It is likely to involve extra expenses ranging from a few dollars for a visit to a doctor and a moderate supply of some of the more common and less expensive drugs, to thousands of dollars for hospital care, surgery, extensive non-surgical treatment by medical specialists, care by private nurses and other paramedical personnel, and expensive drugs and equipment. Many competing insurers provide benefits to meet these needs.

Loss-of-income protection

Since the middle of the nineteenth century insurance companies have been offering individual policies providing periodic cash benefits in replacement of lost earnings if the insured person is unable to work because of illness or injury. For the past thirty years they have been offering the same protection through group policies.

Income benefits usually begin a week or two after the onset of the disability, but

This paper was submitted by the Insurance Liaison Committee of the Medical Society of the State of North Carolina and is the outgrowth of cooperative meetings between the committee and representatives of the North Carolina insurance industry.

waiting periods of a month or more are not uncommon. The use of waiting periods greatly reduces the cost of insurance by eliminating entirely the many short disabilities which do not ordinarily cause the insured a severe economic hardship, but for which benefits would otherwise be payable. Waiting periods in individual loss-ofincome insurance, particularly those of longer duration, also permit the dovetailing of the benefits with other income protection or with salary continuance programs. In both group and individual insurance, the waiting period may apply only to disability resulting from illness, with immediate benefits for disability caused by accident; or the waiting period for accident benefits may be shorter than that for illness benefits.

The duration of income protection benefits varies greatly, and again there may be a difference between accident and illness benefits. Lifetime benefits during disability caused by accident are not uncommon. The most common group policies provide benefit durations of 26 weeks or one year for both accident and illness, while individual policies are more likely to provide benefit durations of two to five years for illness and longer for accident. In all types of loss-of-income protection, a reasonable relationship between benefits and normal earnings must be maintained. Obviously, loss-of-income benefits can ordinarily be provided only for gainfully-occupied persons.

Medical insurance

In addition to losing income because of disability, a sick or injured person incurs extra expenses. Thus it is important for people to have insurance against these costs, both for themselves and for their dependents.

Hospital expense policies generally provide a daily benefit for room and board and general nursing services during hospital confinement, and an additional benefit for other hospital charges. Until the recent development of Major Medical Expense Insurance, the tendency was to in-

crease the duration and the benefits both for room and board and other expenses.

Surgical expense insurance provides for the payment of benefits in the event of surgical or obstetric procedures, in accordance with a fee schedule which lists maximum reimbursement for specified operations. For unlisted operations, amounts consistent with those for listed procedures are usually provided.

Regular medical expense insurance provides rather limited benefits for home, office, or hospital calls, usually providing benefits for hospital calls only. X-ray and laboratory benefits may also be purchased as a supplement to other benefits to provide reimbursement toward the cost of diagnostic services performed outside of the hospital.

The benefits provided are not necessarily expected to reimburse a person in moderate circumstances for the full cost of hospitalization or surgery. More often, they are deliberately set at something less than a full-payment level, so that the patient retains a financial interest in his treatment. In either case, the benefits may be assigned to the doctor or hospital rendering the service, if the insured person so desires.

Major medical expense insurance

The latest advance in the health insurance offered by insurance companies has been the development of major medical expense insurance. This type of policy goes beyond the customary hospital, surgical, and regular medical expense insurance and provides financial protection against lengthy and expensive hospital stays, extensive nursing and medication in or out of the hospital, complicated surgery, or costly treatment by non-surgical specialists. It pays for both hospital and medical services without attempting to say which is which. Coverage is so broad, in most cases, that the cost of treatments not yet thought of will automatically be included within the policy. Occasionally internal limits will be found-for example, no more than a specified daily amount for a private room in a hospital-but usually the only limit on individual items is that they be "reasonable charges for necessary services." There is no financial pressure for the patient to demand or the doctor to prescribe one form of treatment rather than another.

A deductible provision eliminates small claims and also the disproportionate administrative expense associated with them. It takes substantially as many claim forms, filled out by the physician and reviewed by the company, to process small claims as large ones. Although these small claims represent a large element of cost in the aggregate, minor bills can be readily taken care of by the insured and should be provided for by budgeting rather than through insurance.

A co-insurance clause gives the patient a direct financial interest in each dollar of medical or hospital care ordered for him. Financial worries can contribute to illness and retard recovery; on the other hand, if treatment is available without some expense, a person can be encouraged to seek unnecessary treatment or to prolong the treatment. It is undesirable that lack of money should prevent proper treatment. But unnecessary treatment for many people, because they have insurance, will increase the cost of the insurance, possibly to the point that it would be a heavy burden for people to buy it. Companies have tried to solve this dilemma by requiring the patient to pay from his own funds not only the deductible portion of the cost but also a percentage of each additional dollar spent for his medical care. Generally the insurance company's share above the deductible portion is limited to 75 to 80 per cent of the expenses, with the patient paying the remaining 25 or 20 per cent.

The latest development in major medical expense insurance is the introduction and growth of comprehensive insurance. medical expense insurance Major originally thought of as taking over costs subject to deductible and co-insurance, after benefits under a hospital and surgical plan paying from the first expense dollars were exhausted. In comprehensive major medical insurance first dollar hospital and surgical benefits are replaced by major medical benefits which start paying a percentage of costs after a deductible portion. The deductible, often expressed as percentage of the employee's wages rather than as a specified sum of money, is sometimes as low as \$25. While there is sometimes difficulty in introducing such a plan to a group which has been accustomed to first-dollar benefits, employees generally are not slow to realize the advantages of the greater protection afforded by this type of plan.

Group and Individual Insurance

The greater part of the health insurance issued by insurance companies is sold on a group basis. The policy is usually issued to an employer, trustee, association, or union -which is designated the policyholderwith individual certificates usually given to the individuals in the group covered by the master policy. There are various arrangements for sharing the cost between the policyholder and the individuals, ranging from the entire cost being met by the employer or other policyholder to the entire cost being met by the individuals, but generally the policyholder pays part of the cost. Any contribution from employees to the cost is, in most cases, deducted from the employee's wages.

Group insurance has the advantage of economy in selling and in administrative costs. Naturally it costs less to sell insurance to a large number of people at once than to sell it to them one by one. Then, too, it can reasonably be assumed that these people who are joined together by conditions of employment or some other common interest apart from insurance are, on the average, in general good health. In selling insurance to individuals, on the other hand, we find a natural tendency for people already in poor health to seek insurance while people in excellent health are inclined to put off its purchase.

This tendency, which is called anteselection, has to be countered by careful underwriting. Individual insurance usually contains stricter provisions concerning preexisting conditions and waiting periods and more exclusions of specified conditions than does group insurance. Special provisions, such as higher premiums or additional exclusions, are often offered to applicants whose individual prospects of suffering a loss insured against are appreciably greater than that which the standard premium rate was designed to cover. Other than this, the benefits available under individual insurance are similar to those under group insurance, but a greater range of benefits -both higher and lower-is offered under individual insurance.

Group policies can be tailored to the needs of a particular group in a way that is not possible when only one plan of protection is offered to an entire community. They cannot, however, be adjusted to individual needs as effectively as individual needs as effectively as individual policies can. While individual policies cost more than the same protection under group insurance, because of the greater cost of selling and also the greater risk of loss, the higher price is often worth while to those not eligible for group insurance or those who desire additional protection.

Effects of Health Insurance

Health insurance, whether provided on a group or on an individual basis, creates certain problems for the doctor. Among other things, insurance can cause patients to demand certain types of treatment rather than others, or to ask for unnecessary treatment. It raises a question concerning our fees, and it requires us to fill out claim forms. The doctor's cooperation is needed if health insurance is to serve its purpose.

Treatment

If insurance benefits are available when a certain procedure is performed in the hospital, but not when it is performed in the doctor's office, there will be a natural tendency by a patient to seek hospitalization, whether medically indicated or not. This is a pressure, which we as physicians must resist. We must ask: "Does the patient need this procedure? Is this a prudent (not wasteful) course of action?"; not, "Does insurance cover it?"

Insurance companies do not wish to interfere with the doctor's professional judgment. It is the great advantage of major medical insurance, and particularly of comprehensive medical insurance, that it does not interfere. The determination of the course of treatment is left where it belongs, in our hands, not in the terms of the policy.

A similar pressure is the demand for unnecessary treatment—"Because it doesn't cost me anything, doctor." An extra day or two in the hospital, a few extra laboratory tests, a few unnecessary calls on the doctor, taking him away, perhaps, from patients who need him more—no, it doesn't cost this The miracle behind miracles is that in nature there is no surrender.

URPOSE.

In the path of any purposeful effort, there are obstacles that must be expected and overcome. For example, Blue Shield and the decters who support it have not been without their share of problems in planning a program for care of the aged. Yet there has been no thought of giving up, for much has already been accomplished. As one dector sums it up: "Blue Shield Plans already cover people over 65 in the same proportion as they exist in the population at large-and membership is growing at a faster rate in this age group!" BLUE SHIELD.



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Coverage	Lass of Sight, Speech ar Hearing	Accident and Sickness Benefits	Annual Premium	Semi-Annual Premium	Annual	Semi-Annual
5,000	5,000 to 10,000	50.00 Weekly	\$ 78.00	\$ 39.50	Premium \$104.00	Premium \$ 52.50
5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	\$ 32.30 76.50
5,000 5.000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.50
5,000	12,500 to 25,000 15,000 to 30,000	125.00 Weekly	186.00	93.50	248.00	124.50
3,000	13,000 10 30,000	150.00 Weekly	222.00	111.50	296 00	148 50

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particular patient anything at the moment, but it may cost him and all other insured patients something the next time premiums are calculated for his group. (Under group plans, experience is reviewed annually to determine the premium rates.)

Fees for insured patients

The doctor's cooperation is also needed in the matter of fees. Health insurance does affect our income; it is easier to collect our fees, and some people who would otherwise be charity patients are able to pay. It must be remembered, however, that health insurance does not create new money. It simply means that everyone pays the average cost of medical care, instead of most people paying much less than the average and a few people paying—or failing to pay—much more.

As a practical matter, doctors must have some method of determining their fees. We base our charges on the current rates in the community or perhaps on a list of usual fees or relative values published by medical societies. Even though we may make adjustments in individual cases, we have to have a starting point. The criteria a doctor uses for raising or reducing his fees are, in general, up to him. We must not, however, let our fees be influenced by the presence of insurance.

Claim forms

In order to collect the benefits of any insurance policy, the insured person must supply proof that the event insured against has occurred. In the case of health insurance, a doctor's statement is usually an indispensable part of this proof. As a service to their policyholders, insurance companies supply forms, indicating specifically what information is needed, on which this information may be recorded.

With several hundred companies providing some form of health insurance, it is hardly surprising that many different ideas arose as to the information needed and the best way to ask for it. Eventually, however, the insurance industry realized that this multiplicity of claim forms created an undue burden on the busy physician. The

Health Insurance Council's Uniform Forms Program was established to relieve this burden. Companies writing some 80 to 90 per cent of the total business now participate in the program. (The Health Insurance Council forms are required in North Carolina under a regulation issued by the Insurance Commission.)

Because the requirements of the companies, and of the different policies, vary so greatly, it was found impracticable to have all companies use exactly the same forms. Instead, a list of standard questions was developed, and companies are asked to use these questions and no others, in the order in which they appear on the standard list, but with the option of omitting questions or phrases which are inapplicable to the particular policy.

The questions are those necessary to establish the identity of the patient as a person insured by the policy, to show that his condition and treatment are covered by the terms of the policy, and to determine the amount of benefits due. Forms used in conjunction with cost-of-treatment insurance often contain an assignment of benefits, but of course as assignment is not used with statements in support of loss-of-income claims.

A more detailed description of the Health Insurance Council claim forms will be found in the booklet⁽²⁾ recently distributed to all members of the Medical Society of the State of North Carolina.

Summary

The present article has described the types of insurance available from insurance companies to meet the various medicofinancial needs of the public, and has discussed some of the problems health insurance creates for the doctor. A future article will discuss the purposes and principles of health insurance and its effects on medical practice and medical economics as a whole.

References

- Mohr, J. E.: "Third Parties," Government Medicine, and Private Practice, North Carolina M. J. 20:290-292 (Aug.) 1959.
- Simplified Claim Forms for Accident and Health Insurance: A Report to the Physician. Health Insurance Council, New York, 1958.

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JUNE, 1960

ONE HUNDRED SIXTH ANNUAL SESSION

For the first time since 1943 the Medical Society of the State of North Carolina held its annual session in Raleigh. The Sir Walter Hotel was headquarters for the Society and for the Women's Auxiliary, but the meetings of the House of Delegates, registration desk, and technical and scientific exhibits were located in the Reynolds Coliseum on the State College Campus. The Section Meetings on Tuesday and Wednesday afternoons and the alumni luncheons were held in various buildings on the State College Campus. The President's Dinner on Tuesday night was held in the College Union, but the President's Ball was in the Coliseum.

The Wake County Medical Society were most hospitable hosts, but the widely scattered meeting places probably discouraged many from attending the meeting. Seven hundred and sixty-four members were registered, which was only slightly more than the 736 present in 1943.

The Executive Council met on Saturday afternoon and Sunday morning. The House of Delegates had an all-day session Monday from 10:00 A.M. until 5:00 P.M. Only a few of the principal actions of the Council and Delegates will be given here.

The House voted to rescind its action requiring the payment of dues from those who have been members of the Society for 30 years but who are not yet 70 years old. From now on those members who have attained the aged of 70 years and have been members of the Society for 20 consecutive years shall be considered life-members and relieved of paying dues. The "30-year members", however, who have already been given citations as life-members will not be required to pay dues but will not be discouraged if they want to do so on a voluntary basis. It was felt that this loss of revenue would be justified by the better public relations established.

Dr. Wayne Benton, chairman of the Finance Committee, reported that the Society this year had a surplus.

Dr. Hubert Poteat, who reported for the Nominating Committee, asked that district councilors be requested to canvass their districts and offer suggestions for the Society's officers during the coming year. Each councilor is expected to write a letter stating whether or not he has any names to offer.

A resolution by Dr. Amos Johnson that General Sessions programs be planned with a view to offering the widest possible appeal to members in attendance was unanimously adopted.

The most controversial subject was the resolution from the Lenoir-Jones-Green component society to limit the tenure of councilors to two consecutive terms and to stagger the terms of those in office. Although this resolution was rejected by the Executive Council and by the Committee on Constitution and By-Laws, it was evident that many were in favor of it. A motion to table the resolution, however, was defeated by a vote of 55 to 48.

One of the high lights of the House of Delegates Meeting was the address of Mrs. Robert Garrard, President of the Women's Auxiliary. She was given a standing ovation when she finished speaking.

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Dr. W. A. Sams, of Marshall, veteran councilor and an active member of the American Academy of General Practice, was elected General Practitioner of the Year by a clear majority on the first ballot.

A well deserved token of appreciation in the form of a handsome wrist-watch, a gift from the Society, was given our Executive Secretary, Jim Barnes. Jim was deeply touched by this tribute.

The Memorial Service Sunday night was again presided over by Dr. Charles Pugh. The Rex Hospital Nurses Choir furnished music, and Rev. James G. Huggin, Pastor of the First Methodist Church, of Gastonia, delivered an excellent address on Resurrection and Immortality.

Notable features of the first General Session were addresses by Senator Sam J. Ervin, Jr., and Dr. Leonard Larson, Chairman of the A.M.A. Board of Trustees. Senator Ervin declared emphatically that he was opposed to the Forand type of legislation. Dr. Larson's address on the "Socioeconomic Aspects of Medical Practice" was devoted chiefly to a description of the American Medical Association and the way it functions. It is generally understood that Dr. Larson will be the next president-elect American Medical Association. President John Reece's farewell address suffered not at all in comparison with those of our visiting speakers. It appears in this issue of the JOURNAL and is well worth reading, even by those who heard it.

Dr. Louis M. Orr, President of the American Medical Association, was the principal speaker at the President's Dinner. Dr. Orr is a superb speaker, and his address, which was devoted chiefly to the crisis facing us because of proposed legislation in Congress, impressed everyone. Dr. J. P. Rousseau presented the President's Jewel to Dr. Reece in a brief but eloquent address. After this Dr. Reece administered the Oath of Office to the President-Elect, Dr. Amos Johnson. Dr. Johnson did not have a prepared address, but his extemporaneous speech was deeply moving. He paid a beautiful tribute to his wife, who he said had practiced medicine with him for 25 vears.

Mr. Billy Joe Patton, of Morgantonwho is Dr. Leonard Larson's son-in-lawwas toastmaster. He introduced the participants with humor enough to make it interesting.

It is a welcome change from the former custom to have the Nominating Committee bring in its report during the first Session of the House of Delegates. Dr. Claude B. Squires, of Charlotte, is the President-Elect. Other officers elected were Dr. T. S. Raiford of Asheville, first vice-president; and Dr. C. T. Wilkinson of Wake Forest, second vice-president. Dr. Donald Koonce of Wilmington was re-elected speaker of the House of Delegates, and Dr. E. W. Schoenheit of Asheville was re-elected vicespeaker. All these choices met with hearty approval.

Dr. Roussau voiced the general sentiment when he said that while Dr. Reece has been one of our youngest presidents, he has also been one of the best. With Dr. Amos Johnson, his successor for next year, and with Dr. Claude Squires, the president-elect, the Medical Society of the State of North Carolina is in good hands for the next two years at least.

EDITORIAL NOTES

Two criticisms of the meeting, both of which are really constructive, were heard. One was that the luncheons for the three state medical schools should be scheduled for the same day. A great many doctors in the state got the first two years of their medical training at the University of North Carolina or at Wake Forest and their degrees from some other schools, particularly Jefferson, the University of Pennsylvania, and the University of Maryland. The Jefferson luncheon on Tuesday was in conflict with that of the University of North Carolina Medical Alumni, together with the Academy of General Practice and the Society of Internal Medicine luncheons. Although Jefferson has a large group of alumni in the state, the attendance at the luncheon was pitifully small.

Another criticism was that the drawing for attendance prizes took entirely too much time. Although the drawing was scheduled for 12:40 it was almost 2:00 P.M. before it was over. Many made the suggestion that there should be fewer prizes offered and that the drawing be speeded up as much as possible.

Donald Koonce proved himself a worthy successor of Roscoe McMillan and Westbrook Murphy as Speaker of the House of Delegates. He said in the beginning that the mistakes he made last year were made from ignorance but that those made this year would be from stupidity. No one can accuse him of having been stupid.

After the death of Dr. Hubert Royster last year, the vacancy left on the editorial board of the Journal was filled by the selection of Dr. Charles W. Styron of Raleigh. This year the terms of Drs. Ernest Ferguson, Wingate Johnson, and Westbrook Murphy expired. All three of these were re-elected. Dr. Louis L. Klostermyer of Asheville was elected a trustee of the Hospital Saving Association and Dr. Alfred Hamilton of Raleigh was re-elected to the Board of the Hospital Care Association.

The only question mark offered by the Committee to report on President John Reece's addresses concerned his suggestion that the Society should seriously consider having an interim meeting. The Committee felt that there were so many medical meetings already that it would be unwise to add another to the list. The Committee did, however, commend the Committee Conclave held at Pinehurst last December.

It was evident throughout this meeting—as in the meetings held in Asheville—that there is a nostalgic longing for Pinehurst. The fact that for some years the attendence at Pinehurst had been in the neighborhood of a thousand, or even more, is proof that it is a popular place to meet. It is unfortunate that our Northern friends who control the policy of the Carolina Hotel are adamant in their opposition to allowing Negroes to enter its lobby. Let us hope that some day a satisfactory arrangement permitting us to go back to Pinehurst may be worked out.

One of the most interesting features of the session was the address given before the Second General Session by Lieut. Commander Richard T. Arnest, "Life Aboard a Nuclear-Powered Submarine." Lieut. Commander Arnest gave fascinating sidelights on the many factors needed to ensure the success of a long submarine cruise.

The men selected must have excellent physical and psychologic qualifications. A great deal of thought was devoted to the prevention of boredom while on the cruise. This included careful selection of all means of entertainment and of both the food and the cook-since eating was one of the principal ways of passing time. Meticulous care had to be devoted to protection from radiation, also to good water supply and the right sort of air for breathing purposes. Although his address came toward the end of the morning, the speaker was given close attention. It is hoped that the address will be published in a future issue of this JOURNAL.

MEDICAL MINDS MEET IN MOSCOW

In marked contrast to the tragic failure of the summit conference in Paris was a series of conferences going on at the same time in Moscow between American and Russian scientists.

The National Foundation News Letter for May 23 summarizes the report of Dr. Theodore Boyd, the Foundation's chief of virology and epidemiology, and Dr. John Fox, chief of the division of epidemiology of the New York City Public Health Research Institute and a member of the Foundation's Advisory Committee on Virus Vaccine.

The occasion for this meeting of medical minds was to compare notes on the Sabin live virus vaccine which, according to Dr. Boyd, "was given to I5 million Soviet citizens last year. It has now been fed to more than 60 million there and is currently being manufactured in the U.S.S.R. at the rate of several million doses a week,"

"In this country, the Sabin vaccine is still an experimental vaccine," he said. "In Russia it is no longer on trial. It is their polio vaccine of choice, officially accepted for use in an all-out immunization program."

The live virus vaccine is now such a live subject (no pun intended), and the cordial relations between the scientists of both countries so noteworthy, that the joint statement of Drs. Boyd and Fox is quoted from the National Foundation News letter.

"The combination of informal visits to Russian polio research laboratries in MosEDITORIALS 243

cow (May 6-11), official bilateral talks between Russian and American authorities (May 12-16), and an international symposium (May 17-20), all on live-virus vaccines, provided an extraordinary opportunity for sharing of information and produced a mass of scientific data. At the symposium alone, 68 papers and 25 short reports were presented, including eight papers and three reports from the United States.

The experimental oral polio vaccines developed by Dr. Hilary Koprowski, now of the Wistar Institute, and Dr. Herald R. Cox of Lederle Laboratories, as well as the March-of-Dimes-developed Sabin vaccine were discussed. Because the Sabin vaccine has been the most widely used, the bulk of the talks concerned experience with it.

"Our official report to The National Foundation, which sent us to Moscow as participants and observers, will note the following points which we consider to be particularly significant.

"1. Safety. The Russians are completely convinced of the safety of the Sabin experimental vaccine. In the course of giving it to so many millions of Soviet citizens, there were bound to be some cases of polio occurring in vaccinated persons who were infected with natural poliovirus before the vaccine could protect them. When this happens, the question must always be asked, could the vaccine have caused the polio? It is a difficult question to answer. In what we were able to see in the Moscow area, we were impressed by evidence of good Russian laboratory procedures used in trying to rule out the vaccine as the cause when such cases occured, but they have by no means solved the problem yet.

"2. Effectiveness and administration. Guarantee of effectiveness of live-virus polio vaccines is still a problem. A reduction in reported polio in one season after mass use of the vaccine—which occurred in some areas of the U.S.S.R. in 1959—is not sufficient proof of effectiveness because incidence of polio varies unpredictably from year to year. Finding that polio antibodies appear in the blood stream of an individual after vaccination is presumptive evidence that the person has been immunized by the vaccine. But this requires a

laboratory procedure not practical on a mass scale. And the trouble is, live-virus polio vaccines do not always 'take.' Some Russian reports show they get the most 'takes' in the most people by feeding the vaccine on a four-dose basis. Vaccine containing each of the three types of poliovirus is given in separate doses a month to six weeks apart, followed later by a fourth dose containing a mixture of all three types. They report they do not get as good a record of 'takes' when they give just a single dose of a three-types-in-one mixture.

"3. Manufacture. We were impressed by what we learned of mass production of the Sabin vaccine in the Soviet Union. The Russians have produced their vaccine from 'seed' strains originally supplied by Dr. Sabin. Today, in his Moscow Institute laboratories, Prof. Chumakov is making Sabin vaccine at the rate of several million doses a week and believes he can double present output without difficulty. It is being manufactured both as a liquid to be fed in teaspoons of cherry syrup and in the form of candy balls. Details of vaccine production methods, safety tests and potency tests were made available to U.S. Government officials.

"4. Use. Present plans in the U.S.S.R. call for completion of vaccination of the two-months to 20-year age group (estimated at 80,000,000) by the end of this year. The persistence of antibody response is not yet known. Until this has been established, by observation in selected control areas, the general population will receive periodic revaccination. A speaker from Red China reported at the symposium that it has set up its own laboratories for making Sabin vaccine, has already given it to 4 million and plans to immunize its preschool population estimated at 100 million.

"In the United States, where we are already immunized against paralytic polio by Salk vaccine, the problems are somewhat different from those in Europe and other countries. It is still the business of each country to decide for itself about production and use of biologic products. The Moscow meetings were profitable and should provide useful information to those charged with deciding if a live-virus polio vaccine should be used in this country."

Clincopathologic Conference

Bowman Gray School of Medicine of Wake Forest College

EMERY C. MILLER, M.D. and

ROBERT W. PRICHARD, M.D.

A 52 year old white male brass worker was admitted to the hospital because of fever, cough, hemoptysis, hoarseness, and general aching of one week's duration. During this time he had received penicillin parenterally and orally without benefit.

Six months before admission a radiographic diagnosis of duodenal ulcer had been made, and two month before entry a bout of epigastric pain had been followed in two or three days by tarry stools. Easy fatigue followed this bout of melena.

Physical examination: The patient was a well developed, well nourished, acutely ill male who was alert and cooperative. The blood pressure was 140 systolic, 80 diastolic, pulse 88, temperature 102 F., and respiration 16. The buccal mucosa and the turbinates were hyperemic and hemorrhagic. There was questionable tenderness of the thyroid, but no nodules or enlargement were noted. The trachea was in the mid-line. Chest expansion was equal and adequate; fine respiratory rales were heard anteriorly and posteriorly over the left lower and right upper lobes. The cardiac examination was within normal limits. No abdominal masses or organs were felt, although moderate periumbilical tenderness was noted. The left testicle was missing. The remainder of the examination was within normal limits.

Laboratory findings: The hemoglobin ranged between 9 and 11 Gm., and the white blood cell count between 6,000 and 12,000, usually with a shift to the left. Urinalysis: the specific gravity never exceeded 1.006, and persistent 2 plus proteinuria was observed. Sugar and acetone were negative, but 10 to 15 red cells and a few white cells and casts were found persistently. The blood urea nitrogen rose during hospitalization from 25 mg. per 100 cc. The serum sodium ranged from 133 to 138, serum potassium from 4.1 to 5.3; the carbon dioxide was 27.9 and chloride 94 mEq.

per liter. Heterophile, cold, and febrile agglutination studies were all negative, as were blood and urine cultures. The antistreptolysin O titer was 50 units, and the C-reactive protein was strongly positive. A sputum culture on admission showed normal flora, together with a few beta hemolytic streptococci. A repeat culture on the seventh hospital day following extensive antibiotic therapy showed mixed gramnegative flora. Sputum on the ninth day was reported as positive for malignant epithelial tumor cells. All cultures and smears for acid-fast bacilli were negative. A roentgenogram of the chest showed a poorly circumscribed infiltrative density in the periphery of the right upper lobe.

Hospital course: The patient was placed on an ulcer regimen on admission and was also started on chloramphenicol, 1 Gm. given intramuscularly twice daily. Since the pulmonary symptoms and fever persisted despite this treatment, tetracycline was substituted on the fourth day. As the fever, with tachycardia and tachypnea, continued, penicillin (200,000 units every three hours) was added on the fifth day, without appreciable results. On the eighth hospital day severe sclera and conjunctiva injection was observed. Because of the persistence of the symptoms and the lack of response to antibiotics, tetracycline was discontinued and Furadantin added in the dosage of 100 mg. every six hours given orally. At this time it was noted that grayish membranous lesions now involved the uvula, palate, left anterior pharyngeal pillar, and nasal mucosa. These were associated with a mucoid discharge; on stripping of the lesions the underlying mucosa bled freely. As time passed the lesions became edematous and ulcerative, but histologic examination revealed only necrotic hemorrhagic exudate. Studies for diphtheria organisms were negative. Indirect laryngoscopic examination at this time showed the left cord to be thickened and the right cord to be partially involved by a granular, bleeding purulent mass measuring 3 cm. in diameter.

Respirations became increasingly difficult because of the profuse, tenacious, mucoid sputum and hemoptysis, and a bronchoscopy was performed on the sixteenth day. Bronchoscopy revealed old blood in the trachea and diffuse granulomatous involvement of the trachea and bronchi. The carina could not be seen because of inspissated secretions. Histologic examination of the lesions was reported as showing an extensive ulcerative process which penetrated the mucosa and submucosa and was considered granulomatous, although there was a generalized central necrosis. Cytologic studies of secretions were again reported positive for malignant epithelial tumor cells.

Despite all antibiotic therapy and frequent blood transfusions, the patient died

a few hours after bronchoscopy.

Clinical Discussion

DR. EMERY MILLER: While I do not share the general opinion that a clinicopathologic conference is particularly valuable as a teaching exercise, I do think it is an interesting game. Like all games it should be played according to rules, and the rules are (1) that the clinician should not know the diagnosis in advance, (2) that the pathologist should know the diagnosis (or, at least, a diagnosis), and (3) that the protocol should contain the pertinent evidence upon which to base a correct diagnosis. It is the duty of the pathologist to call the clinician's attention to that information should the clinician fail to reach a correct diagnosis, and point out how the correct final diagnosis is not only made possible by the information contained in the protocol, but inevitable.

Our protocol tonight is a fair one, and this clinician can only plead ignorance if he errs.

Two fundamental principles apply to the successful conduct of a clinical discussion. The first is that if it is possible to account for all the conference findings on the basis of a single diagnosis, it is wise to do so. I must confess that I am unable to do so here. The finding that seems unrelated to the major problem presented by this patient is the presence on two occasions, on cytologic study of bronchial secretions, of malignant epithelial tumor cells. I believe that this finding must be related to a secondary diagnosis or else be erroneous, and that in any event it has no bearing on the patient's primary problem and cause of death. (At this point slides of the cells considered elsewhere to be malignant epithelial tumor cells were presented by Dr. Smith Foushee. He classified them as inflammatory rather than malignant cells).

If one accepts Dr. Foushee's opinion concerning these particular cells, it is unnecessary to account for them by a secondary diagnosis. Inflammatory cells in bronchial secretions fit well into the over-all picture presented by this patient.

If the original impression that malignant cells were present had been sustained, I should have offered as a secondary diagnosis, unimportant to the basic problem, the speculation that the patient's left testicle was missing because it had been surgically removed for an embryonal carcinoma which had subsequently metastasized to the lung, giving rise to the malignant epithelial tumor cells observed.

The second finding that I am unable to account for fully on the basis of a single diagnosis is the history and x-ray diagnosis of duodenal ulcer, although on this point I should like to hedge until later in my discussion by referring to an article by Nightingale⁽¹⁾ in the American Journal of Gastroenterology in 1959.

The second basic principle of diagnosis in a clinicopathologic conference is to give proper weight to the various clinical findings. I am inclined to attach significance to two general types of findings. One is those which are simple and objective to such a degree that they can hardly be misinterpreted. Any third year medical student and even some sophomore medical students would be capable of making this kind of observation. An example might be taken out of the first paragraph of the protocol that "this was a 52 year old white male." The second kind of helpful clinical information is symptoms or signs that are relatively specific and by their relative specificity limit the range of possibilities. An example of such a symptom would be hemoptysis, which should imply a necrotizing or destructive lesion involving the upper respiratory tract. Examples of the kind of information contained in the protocol that I consider unimportant because it is neither objective nor relatively specific are such symptoms as "generalized aching of one week's duration" and "cough."

By applying these criteria to the protocol we can select the findings to which we will attach some weight in arriving at the final diagnosis. They include the fact that this is a 52 year old white male who has had hemoptysis. On physical examination the temperature is 102 F.: hence the patient has a febrile illness. Most of the information derived from the physical examination is not particularly helpful. The lung findings are of some interest, but the chest roentgenogram will be more valuable. No abdominal masses or organs are felt, so that the patient does not have splenomegaly. "The remainder of the examination was within normal limits": hence there is no skin involvement.

Particular interest is attached to the urinary findings of persistent 2 plus proteinuria and hematuria. Blood urea nitrogen rose during hospitalization from 25 to 70 mg. per 100 ml. Such evidence is both objective and relatively specific, and any clinical diagnosis must account for definite renal involvement. Smears and cultures of the sputum are negative despite the obvious necrotic lesions of the mucous membranes.

X-ray examination of the chest reveals poorly circumscribed infiltrative densities in the periphery of the right upper lobe suggestive of granulomatous disease. It is to be noted that there is no evidence on physical examination or in that portion of the bony cage shown on the routine chest roentgenogram of any bone involvement.

The important evidence to be picked out of the description of the hospital course is the fact that whatever the patient's inflammatory process might be, it is not responsive to penicillin in doses that are adequate for most diseases that are responsive to penicillin. The presence of greyish, membranous lesions involving the uvula, palate, left anterior pharyngeal pillar and nasal mucosa is uncommon, and this is one of the findings that may be described as relatively specific. Laryngoscopy a short time afterward gives us a finding that is even more specific, and that is that the left cord is thickened and the right cord is partially involved by a granular, bleeding, purulent mass 3 cm. in diameter. Thus this is a disease with definite granulomatous involvement of the larynx.

The final point of helpful information is the biopsy report in which an extensive penetrating ulcerative process is described, considered to be granulomatous despite the fact that there is generalized central necrosis. This is an unusual pathologic description, The immediate cause of death does not pose much of a problem. A number of factors may well have contributed. The patient had an anemia of moderate degree, and the toxemia of a generalized inflammatory process. In addition he had uremia. Finally, in view of the extensive involvement of the mucous membranes and the larynx, the possibility of asphyxia is to be considered. Since any one of these four conditions might in itself account for the patient's death, it is not improper to postulate that the combination of the four proved lethal.

To turn now to a consideration of the possibilities in the light of the findings that have been selected from the protocol as meriting attention, eight diseases may be considered in the differential diagnosis. First, membranous involvement of mucous membranes suggests diphtheria. Against this possibility are the facts that diphtheria is primarily a disease of children, that the organism is readily cultured from material obtained from just beneath the membranous lesion, and finally, that this patient's illness was unresponsive to penicillin. There was also no apparent clinical evidence of myocarditis, usually a feature of fatal diphtheria.

Tuberculosis, a second possibility, may be quickly eliminated. One does not acquire tuberculous laryngitis without tubercle bacilli in the sputum.

Lues is ruled out by the total failure of the patient's disease process to respond to fairly high doses of penicillin.

Sarcoid occurs primarily in Negroes, and is rarely fatal. The chief evidence against the diagnosis of sarcoid in this particular patient is the biopsy description of mucosal and submucosal ulceration with necrosis. Necrosis is a rare and unlikely feature in sarcoid, and case reports of sarcoid involving the larynx describe rather a submucosal infiltration with gradual over-all constriction of the lumen.

Fifth, actinomycosis is characterized by skin and bone involvement, both of which are missing in this patient. Renal involvement in actinomycosis is rare; renal involvement is a prominent feature of this patient's course. And finally, actinomycosis is responsive to penicillin.

Except for penicillin-responsiveness, the same arguments may be advanced against the possible diagnosis of nocardiosis.

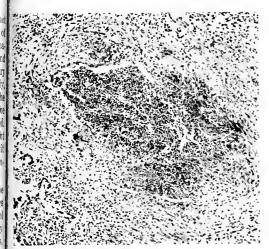


Fig. I. Pulmonary granuloma with central necrosis and giant cells of Langhans type at edge (H. and E. stain, x 100).

Seventh, blastomycosis does, rarely, involve the larynx and the kidney. Its most characteristic clinical feature is the presence of bone involvement. Skin involvement is common.

I believe that the second best possibility as to the final diagnosis is histoplasmosis. It affects the larynx with some frequency, it is universally (except for laboratory infection) primary in the lung, and it is an extremely common illness, some estimates of the incidence ranging up to 30 million cases in the United States alone. Involvement of the kidney is rare in histoplasmosis, and splenomegaly and/or hepatomegaly are relatively common, so that these features of our patient's course do not fit this diagnosis perfectly.

We come now to the final possibility which exactly fits in all known details the clinical course presented by our patient. This was described initially by Klinger (2) in 1931 as lethal mid-line granuloma, with emphasis on the necrotizing granulomatous lesions of the upper respiratory tract. In 1936 Wegener (3) called attention to the fact that the granulomatous changes of the upper respiratory tract are but part of a picture characterized by glomerulitis and further by an arteritis disseminated throughout many organs. Lung involvement is a common, although not consistent, feature of the illness. There is a predilection for males, all reported cases are fatal, bacter-

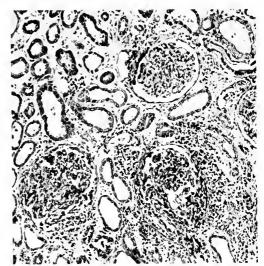


Fig. 2. Glomerulitis and periglomerulitis of type which involved almost all glomeruli (H. and E. stain, x 115).

ial studies are negative, and the process is obviously unresponsive to antibiotics. Involvement of the larynx is common. The disease has been nicely reviewed by Fahey and associates⁽⁴⁾ in the American Journal of Medicine, and recently by Blatt and others⁽⁵⁾ in the Archives of Otolaryngology. The disorder is apparently an off-brand of periarteritis nodosa, and I doubt that any useful purpose is served by classifying it as a separate entity. This case represents, I believe, the one hundred twenty-fifth case of Wegener's granulomatosis recorded in the literature.

As a secondary diagnosis, one must suggest duodenal ulcer, since common things are common. Nightingale, however, points out that the gastrointestinal changes of periarteritis nodosa may closely mimic the clinical picture of peptic ulcer, so that it is attractive to suggest that the x-ray findings described in the protocol are part of the basic disease. One can thus return, by this devious route, to the first Oslerian principle of the art of CPC-manship and account for all the findings on the basis of a single diagnosis—namely, Wegener's granulomatosis (periarteritis nodosa).

One might add some comments on therapy. Blatt and associates emphasized that operative manipulations have an unfavorble effect on the course of the disease. It is

perhaps true that the bronchoscopic procedure performed on the sixteenth day would not have been performed had the proper diagnosis been suspected. These authors also emphasized the value of high steroid dosage in preserving the integrity of tissues and minimizing necrosis, although they did not feel that the basic process is influenced by such therapy. Those patients who have survived for the longest time have been patients on high-dosage steroid therapy. The possibility of peptic ulcer is a relative contraindication to the use of steroids, but in view of the universally fatal outcome such therapy would be justified. An ulcer regimen should obviously be given concomitantly. Survival, however, is usually measured in months.

Clinical Diagnosis

Wegener's granulomatosis (periarteritis nodosa)

Pathologic Discussion

DR. PRICHARD: Wegener's granulomatosis is the diagnosis which we made on this material. Hesitant though I am to persist in the use of eponyms, I have no better substitute. There were lesions throughout the respiratory tree (fig. 1) and there was an active gastric peptic ulcer. Renal involvement was noteworthy (fig. 2) emphasizing the observation that death in these patients usually results from renal failure, even though the disease commonly presents in the respiratory tract. The splenic lesion was granulomatous, with marked central necrosis.

There was a significant degree of squamous metaplasia in this patient's respiratory epithelium and I think it likely that exfoliated metaplastic squamous cells were the suspicious cells which occasioned concern in the smears from his bronchial aspirate.

The morbid state called Wegener's granulomatosis does seem to represent a variety of vasculitis, and a superficial view might lead one to question its separation from polyarteritis nodosa. However, the very marked general necrotizing tendency manifested in the respiratory lesions, the relatively inconspicuous involvement of blood vessels in the same area, and the distinctive initial localization in the air passages seem to me sufficient to set this apart from poly-

arteritis nodosa. Such separation is in keeping with the present trend to group the manifestations of what are often called diseases under the heading of syndromes. This growing practice has an agreeable flexibility consistent with what I hope is a more sophisticated attitude toward disease than the "one cause—one effect" ideas which most of us cherished as sophomore medical students. After all, syndromes and diseases are artificial, created to facilitate diagnosis, treatment and prognosis, and if a concept such as Wegener's granulomatosis allows desirable improvement in these areas, we may pragmatically wish to keep it for reasons other than CPC's.

Pathologic Diagnosis Wegener's Granulomatosis

References

- Nightingale, E. J.: The Gastroenterological Aspects of Periarteritis Nodosa, Am. J. Gastroenterol. 31:152-165 (Feb.) 1959.
- Klinger, H.: Grenzformen der Periarteriitis nodos Frankfurt Ztschr. f. Path. 42:455-480, 1931.
- Wegener, F.: "Uber generalisierte, septische Gefäs erkrankungen, Verhandl. d. deutsch. path. Gesellsch. 29:202-210, 1936.
- Fahey, J. L., Leonard, E., Churg, J., and Godman, G. C.: Wegener's Granulomatosis, Am. J. Med. 17:168-179 (Aug.) 1954.
- Blatt, I. M., and others: Fatal Granulomatosis of the Respiratory Tract (Lethal Midline Granuloma—Wegener's Granulomatosis), Arch. Otolaryngol. 70:707-749 (Dec.) 1959.
- Walton, E. W., and Leggat, P. O.: Wegener's Granulomatosis, J. Clin. Path. 9:31-37 (Feb.) 1956.

A program to further international relations for the United States by making it possible for medical students to serve as unofficial ambassadors, has been announced by the Association of American Medical Colleges and Smith Kline & French Pharmaceutical Company.

Established by a \$180,000 grant from Smith Kline & French, the new program will provide foreign fellowships through which students of United States medical colleges may travel abroad for a limited period time to work in remote areas of the world.

Any students who has completed his third year of medical school is eligible to apply for a fellowship. If accepted he may spend 12 weeks or more at a foreign mission or other remote private medical facility, or a public health unit, clinic or hospital.

Medical students who wish to apply for a fellowship must submit their application to the dean of their medical school. If the application is acceptable, the dean will then endorse it and forward it to the Selection Committee at the Association of American Medical Colleges.

Committees and Organizations

AN APPRECIATION AND A RESOLUTION North Carolina State Board of Health May 11, 1960

The North Carolina State Board of Health expresses its gratitude to Dr. John Homer Hamilton for the lifetime of service that he has rendered to the State of North Carolina through the medium of public health.

Born in Ash Grove, Missouri, Dr. Hamilton moved with his family to Oklahoma while he was still a boy. He graduated from Oklahoma Agricultural and Mechanical College in 1910; taught science in Cherryvale, Kansas, 1910-1911; served as a chemist at the Institute of Animal Nutrition, Pennsylvania State College, 1911-1912; entered the Harvard Medical School in 1912, and graduated with a medical degree in 1916.

After graduating from Harvard, he served as Associate Bacteriologist, Division of Laboratories and Research, New York State Department of Health, 1916-1918. He then became Associate Professor of Preventive Medicine and Assistant Director, State Public Health Laboratory, University of Iowa, 1918-1919.

He served as Associate State Director, International Health Division, Rockefeller Foundation, 1919-1920.

Dr. Hamilton came to North Carolina in 1920 as County Health Officer for New Hanover County, and in 1931 he came to the State Board of Health, where he became Director of the Division of County Health Work and Epidemiology.

In 1933 he became the second Director of the North Carolina State Laboratory of Hygiene. He has been Assistant State Health Director since 1951 and editor of The Health Bulletin since 1942.

Dr. Hamilton believes, with a great many other thoughtful people, that next to the ministry of religion the ministry of health constitutes the noblest calling in which man can engage. He has devoted a lifetime to the ministry of public health, and by example and encouragement has inspired young people to enter, to remain in and to give dedicated service to the profession. Thus, his influence is felt around the world.

Concurrent with his work in public health, Dr. Hamilton has served as an officer in several professional associations and is affiliated with various medical, public health, and cultural organizations. He is a member of the Raleigh Academy of Medicine, Wake County Medical Society, Medical Society of the State of North Carolina, the American Medical Association, and the Southern Medical Association.

In 1928 Dr. Hamilton served as president of the North Carolina Public Health Association and in 1944 took leadership in promoting the Laboratory Section of the Association. He is a Fellow of the American Public Health Association, Charter Member and Fellow of the American College of Preventive Medicine, and a Member of the Conference of State and Provincial Public Health Laboratory Directors. In 1946 he served as president of the North Carolina Academy of Public Health, and in 1954-1955, as president of the North Carolina Academy of Preventive Medicine.

Dr. Hamilton is a member of the North Carolina Harvard Club, Executives Club of Raleigh, State Literary and Historical Association of North Carolina, and the North Carolina Society for the Preservation of Antiquities. He is a member of the White Memorial Presbyterian Church in Raleigh.

In his contact with the staff and employees of the State Board of Health and with the people of North Carolina, Dr. Hamilton is first and foremost kind, understanding and considerate. His judgment and wisdom are keystones on which public health workers all over North Carolina have come to rely.

His appearances before appropriating and governing bodies in support of health programs in North Carolina have been models of accuracy, pin-pointing the salient facts of each bill, stressing economy of state money, the greatest service to the greatest number of citizens, and keeping public health in its proper perspective in relation to the total health program.

The State Board of Health, recognizing his qualities of leadership, patience, wisdom, and kindness, is deeply grateful to Dr. Hamilton for his devoted service to public health and wishes for him many years of health and happiness.

BULLETIN BOARD

COMING MEETINGS

Duke University Postgraduate Medical Course— Morehead-Biltmore Hotel, Morehead City, July 18-23.

North Carolina State Board of Medical Examiners—Battery Park Hotel, Asheville, Juy 22.

North Carolina Academy of General Practice, Mecklenburg Chapter—Charlotte Hotel, Charlotte, November 8.

Southern Obstetric and Gynecologic Seminar—Grove Park Inn, Asheville, July 28-August 3.

North Carolina and South Carolina Eye, Ear, Nose and Throat Societies Joint Meeting—Hotel King Cotton, Greensboro, September 11-14.

Southeastern States Cancer Seminar for Physicians—Cherry Plaza Hotel, Orlando, Florida, November 16-18.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of May, 1960:

Dr. Bernard Leslie Richards, 1128 Spring Street, Mocksville; Dr. Joachim Dieter Geratz, University of North Carolina School of Medicine, Chapel Hill; Dr. Edward Bloxton Mabry, Medical Village, Burlington; Dr. Edgar Archer Dillard, Jr., 433 Ridgefield, Chapel Hill; Dr. Barbara Steiner Lipton, 1114 Williams Circle, Chapel Hill; Dr. Sara Jamison Dent, Duke University Medical Center; Dr. William Charles North, 1514 Fir St., Durham; Dr. William A. Leonard, 823 North Elm St., Greensboro; Dr. Robert Lewis Phillips, 1500 Independence Rd., Greensboro; Dr. Powell Graham Fox, Jr., 1110 Wake Forest Rd., Raleigh; Dr. William Walker Allen, Pinehurst Surgical Clinic, Pinehurst; Dr. Bill Joe Swan, Arbor Lane, Concord; Dr. Charles Rex LaGrange, Bor 208, Bladenboro.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE

On Monday, June 6, 53 seniors received the doctor of medicine degree from the Bowman Gray School of Medicine in ceremonies held in Wait Chapel on the Wake Forest College campus. The principal speaker for the occasion was Dr. Lam Chi-Fung, president of Hong Kong Baptist College and the father of Bowman Gray senior of the class of 1960, Samuel Lam.

Eight of the graduates remained in North Carolina for their internships—six at the North Carolina Baptist Hospital and two at Cone Memorial Hospital in Greensboro. The remaining 45 will intern as far south as Tampa, Florida, as far north as Buffalo, New York, and as far west as Seattle, Washington.

A master of science degree was conferred on Robert Parker Pulliam, post-sophomore research fellow, who spent the past year in research training with Dr. Richard L. Burt in the Department of Obstetrics and Gynecology. The title of Mr. Pulliam's thesis is, "Carbohydrate Metabolism in Pregnancy. Capillary-Venous Differences of Glucose and Lactate Following Insulin."

Eight students at Bowman Gray School of Medicine were recently cited for special achievements in medical writing and over-all scholastic attainment during several phases of medical education.

Four awards for medical writing were presented. The Student Thesis Award in Psychiatry was won by Donald M. Larson of Devils Lake, North Dakota. This annual cash award is made possible through the support of the Smith Kline and French Foundation of Philadelphia to the American Psychiatric Association, and is given to the senior student in this school writing the outstanding thesis on one aspect of psychiatry.

The Best Student Paper Award, a cash award for the best literary and scientific student paper, was received by Robert Park Pulliam of Beckley, West Virginia.

The Frederick R. Taylor History of Medicine Award was won by three rising juniors—George Podgorny of Tehran, Iran, and Mr. and Mrs. Ralph Siewers of Winston-Salem. This award is given annually to sophomore medical students writing the best history of medicine papers.

General scholastic awards were as follows:

The newly established Faculty Award, an appropriately engraved wall plaque, was presented to Fay Knickerbocker Myers of Gainesville, Georgia. This award is made to a graduating senior selected by the faculty on the basis of outstanding scholarship and character.

The Pediatric Merit Award was presented to H. Bee Gatling of Charlotte. Dr. Richard C. Proctor, associate professor of psychiatry, established this annual cash award in honor of his father, Mr. C. K. Proctor. It is presented to a student selected by the faculty of the Department of Pediatrics on the basis of all-round ability and interest in pediatrics and in the care of children.

The Roche Award was given to James Norris Wilfert, Jr. of Tenafly, New Jersey. This annual award, a fine watch, is given to a student selected by the basic science faculty at the end of the first five quarters of the curriculum for scholastic achievement in the basic medical sciences. It is made possible through the courtesy of the Roche Laboratories, Hoffman-LaRoche, Inc., of Nutley, New Jersey.

Dr. Robert L. McMillan, professor of clinical internal medicine, was recently presented with a silver medallion and cited as the "parent" of the North Carolina Heart Association at the group's annual meeting in Raleigh. Dr. McMillan was organizer and the first president of the state group and also founded the Forsyth County Chapter.

Dr. Weston M. Kelsey, professor of pediatrics, has been appointed an examiner with the American Board of Pediatrics.

Dr. Thomas B. Clarkson, associate professor of experimental medicine, and Dr. Hugh B. Lofland, assistant professor of biochemistry, are the coauthors of a paper, "Therapeutic Studies on Spontaneous Atherosclerosis in Pigeons," which was presented at the International Symposium on Drugs Affecting Lipid Metabolism held in Milan, Italy, June 2-4.

Two staff members of the Department of Obstetrics and Gynecology presented papers at the eighty-third annual meeting of the American Gynecological Society held in Williamsburg, Virginia, May 30-June 1.

Dr. Frank R. Lock, professor of obstetrics and gynecology, delivered a paper entitled "Stage-One Carcinoma of the Uterine Cervix: A Comparison of Results with Variations in Treatment." Dr. Richard L. Burt, also a professor in the department, spoke on, "Plasma Nonesterified Fatty Acids in Pregnancy. Experimental Modification."

* *

Mr. Murray Alexander Falconer, director of Guy's Maudsley Neurological Unit, Maudsley Hospital, London, England, visited the medical school recently for three days as the guest of the Section of Neurosurgery. Mr. Falconer is a Fellow of the Royal College of Surgeons, England, and has published approximately 80 publications in neurology and neurologica surgery.

Four professors at the Bowman Gray School of Medicine were among 12 North Carolina scientists who recently received grants-in-aid totaling \$85,157 to conduct research on diseases of the heart and blood vessels. These grants were made possible by the national research program of the American Heart Association.

The Bowman Gray recipients are: Dr. Thomas B. Clarkson, associate professor of experimental medicine-\$6,765 to evaluate the effectiveness of various drugs in dissolving deposits of fat that develop in the arteries of pigeons; Dr. Harold D. Green, professor of physiology and pharmacology, \$8,800 to investigate the cause of disturbances in blood circulating to the arms and legs by measuring blood flow in the skin; Dr. J. Maxwell Little professor of pharmacology-\$9,233.50 to study the hormone balance of animals with experimentallyproduced high blood pressure; and Dr. Merrill P. Spencer, associate professor of physiology and pharmacology-\$7,590 to study basic disease mechanisms of the heart and circulation by direct measurement of blood flow in unopened blood vessels.

NEWS NOTES FROM THE DUKE UNIVERSITY SCHOOL OF MEDICINE

William B. Waddell, a Duke University medical student, has been elected national president of the Student American Medical Association.

A rising junior from Galax, Virginia, Waddell was chosen during the Association's annual convention in Los Angles, California. He succeeds William Kirkland of the University of Oklahoma Medical School.

Stuart Nichols of the Medical College of Virginia was named head of the Association's Region I, which comprises chapters in 12 Southeastern medical schools, succeeding Tom Ivey of the Bowman Gray Medical School in Winston-Salem.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Nathan A. Womack, head of the Department of Surgery of the University of North Carolina School of Medicine, was elected president of the National Board of Medical Examiners at a recent meeting of the board in Philadelphia.

More than 100 alumni attended the University of North Carolina Medical Alumni luncheon held at the State Medical Society meeting in Raleigh on Tuesday, May 10.

Speakers for the occasion were Dr. W. Reece Berryhill, dean of the School of Medicine; Dr. Carl Anderson, assistant dean; and Carwile LeRoy of Elizabeth City, fourth year medical student, who is president of the Alpha Omega Alpha Honorary Medical Fraternity and president of the Whitehead Medical Society.

Three awards were presented recently at the annual Student-Faculty Day sponsored by seniors of the University of North Carolina School of Medicine.

Karl Lee Barkley, second year student from Raleigh, received the William deB. MacNider Award established by the second-year class of 1950 for recognition of a sophomore who is elected by his classmates on the basis of characteristics typified by Dr. "Billy" MacNider during his 51 years as teacher and physician at U.N.C.

The Professor Award presented annually by the senior class to the faculty member "who by his willingness, understanding, and ability has contributed most to our medical education" went to Dr. Kenneth M. Brinkhous.

Dr. Henry L. Stephenson, class cf 1955, and resident in medicine, received the Henry C. Fordham Award established by the senior class of 1958 in honor of the late Dr. Henry C. Fordham, resident in medicine at the N. C. Memorial Hospital. The senior make this award each year to a member of the house staff "in recognition of his qualities of patient, humility, and devotion to medicine as were possessed by Dr. Fordham."

Dr. Charles L. Johnston, Jr. of the University of North Carolina School of Medicine has been named a senior research fellow by the U. S. Public Health Service.

The young physiologist was among 44 fellows named in 32 universities and medical schools throughout the United States. He was the only North Carolinian to receive one of the fellowships, which give financial support for a five-year period or research.

The appointment of Dr. George Pierey Vennart as associate professor of pathology in the School of Medicine has been announced by Chancellor William B. Aycock and Dean W. R. Berryhill. Dr. Vennart will begin his new duties July 1.

Dr. Vennart took his M.D. at the University of Rochester, taught at U.N.C. in 1954-1956 and has been an assistant professor at Columbia University since.

Dr. George Ham, chairman of the Department of Psychiatry, discussed "Reintegration of Psychoanalysis into Teaching" at a recent meeting of the Psychotherapy Section of the American Psychiatric Association in Atlantic City. He also participated in meetings of the American Psycheanalytis Association and the Academy of Psycheanalysis.

On his northern trip Dr. Ham also visited two medical facilities to serve as consultant on medical education programs. One was in Stockbridge, Massachusetts, at the Auston Riggs Medical Center; the other was the Seton Hall College of Medicine in Jersey City, New Jersey where he advised on curriculum development.

Three third year students and eight fourth year students have been selected for membership in the Alpha Omega Alpha Honor Medical Society at the University of North Carolina School of Medicine.

The third year students were Clark M. Hinkley, Waynesville; Edward A. Sharpless, Wilson; and Zebulon Weaver of Asheville.

The fourth year students were Charles P. Eldridge, Jr., Raleigh; James R. Harper, Snow Hill; William N. Michal, Jr., Chapel Hill; William H. Morris, Jr., Charlotte; Jerry M. Petty, Gastonia; William A. Reid, Asheville; Charles W. Robinson, III, Charlotte; and John J. White, Jr. of Henderson.

Selection to the A.C.A. is based upon high academic standing, moral character, and promise of future contribution to the field of medicine.

The State Advisory Budget Commission recently authorized construction of a medical science research building for the University of North Carolina in Chapel Hill.

The 45,000-square-foot structure is to cost \$1,182,977. Funds for its construction will come from a \$528,674 federal grant, a \$500,000 escheat's fund loan and \$154,303 in research overhead receipts.

A delegation of university officials and members of the board of trustee's executive committee, led by Consolidated University President William C. Friday, appeared before the commission to request approval for the project.

The delegation said the escheat's loan would be repayed at the rate of \$50,000 per year. They said the money would come from increased receipts from the expanded medical research program.

Groups having medical research projects conducted by the university pay overhead expenses.

Dr. Nathan A. Womack, chief surgeon at North Carolina Memorial Hospital at Chapel Hill, has been named president of the United Medical Research Foundation to succeed Dr. Eben Alexander, head of the Department of Neurosurgery at Bowman Gray School of Medicine and chief of the medical staff at Baptist Hospital.

Dr. Womack's selection was made at a meeting of the foundation's board held in Winston-Salem. Most of the foundation's funds go to support pilot research studies at the state's three medical schools, Bowman Gray, Duke and U.N.C. Last year the three institutions received \$30,000 each from the foundation. This year's budget calls for \$133,500 for this purpose. The work is supported by United Fund agencies.

At the meeting Dr. Charles Hooker, chairman and professor of anatomy at U.N.C., was named to the executive committee.

Dr. Ernest H. Wood and Dr. Charles A. Bream of the Department of Radiology attended the annual meeting of the Association of University Radiologists in Dallas, Texas, recently.

Dr. Wood is president of the Association, whose membership is composed of radiologists engaged in full-time academic radiology and radiological research.

Dr. Lucie Jessner of the Department of Psychiatry, addressed the Pan American Medical Conference which was held in Mexico City, Mexico, May 2-11.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Colonel D. Bessinger, Jr., of Asheville, a senior at the University of North Carolina School of Medicine, is one of 28 American medical students who will go into the dark corners of three continents this summer and winter to study "grassroots" medicine.

As winner of a Smith Kline & French Foreign Fellowship grant for \$1,985, he will spend 12 weeks at a mission hospital at Mati, Davao, Philippine Islands. Guided by physicians already practicing in remote areas, the Fellows will help to organize and maintain public health programs and—at the same time—gain valuable clinical experience under their proctors.

BULLETIN BOARD

North Carolina Academy of General Practice

Mecklenburg County Chapter

The Mecklenburg County chapter of the North Carolina Academy of General Practice announces that it will sponsor a postgraduate symposium to be held on November 3, 1960, at the Charlotte Hotel in Charlotte.

NORTH CAROLINA STATE BOARD OF MEDICAL EXAMINERS

The Board of Medical Examiners will meet at the Battery Park Hotel, Asheville, on Friday, July 22, at which time applicants for license by endorsement will be interviewed.

NORTH CAROLINA HOSPITAL ASSOCIATION

The American Hospital Association has recommended that Blue Cross be selected by federal employees as their health insurance.

The federal government has initiated a health insurance program for its employees, known as the Federal Employee Health Benefit Act. During the month of June, two million employees will select the type of health insurance coverage they want for themselves and their families.

AMERICAN COLLEGE OF GASTROENTEROLOGY

The American College of Gastroenterology announces that its annual course in postgraduate gastroenterology will be given at the Bellevue-Stratford Hotel in Philadelphia, Pennsylvania, on October 27, 28, 29, 1960.

The faculty will be drawn from the medical schools in and around Philadelphia. The subject matter to be covered from a medical as well as surgical viewpoint will be essentially the advances in diagnosis and treatment of gastrointestinal diseases and a comprehensive discussion of diseases of the mouth, esophagus, stomach, pancreas, spleen, liver and gallbladder, colon, and rectum.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

SOUTHERN REGIONAL EDUCATION BOARD

Ten in-service training grants totaling \$2,260 have been made recently to North Carolina mental health personnel by the Southern Regional Education Board under its program in mental health training and research.

Individual grants up to \$500 are available to any employee of a mental health out-patient clinic, mental health center, state commission or division of mental health in any of the 15 states supporting the S.R.E.B.'s mental health program. A \$76,000 grant to S.R.E.B. from the National Institute of Mental Health supports the program.

Applications for grants are now being accepted by S.R.E.B., and will be acted upon as received. There is no deadline. Interested persons should write to Southern Regional Education Board, 130 Sixth Street, N. W., Atlanta 13, Georgia.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part I and requests for re-examination in Part II, are now being accepted. All candidates are urged to make such application at the earliest possible date. Deadline for receipt of applications is August I, 1960. No applications can be accepted after that date.

The following change in requirements for certification was made by the members of the American Board of Obstetrics and Gynecology at the recent annual meeting in Chicago.

"A Resolution was passed at the recent annual meeting of this Board which eliminates the submission of Case Reports as part of Part I Examination. It is required, however, that each candidate eligible to take the Part II Examination bring to the place of examination, a duplicate list of Hospital Admissions as submitted with his or her application. This change in requirements is not retroactive and therefore applies to candidates making application for the 1961 examinations."

It has also been resolved by members of the Board that Applications for Appraisal of Incomplete Training will no longer be accepted for review by the Residency Review Committee.

Robert L. Faulkner, M.D. 2105 Adelbert Road Cleveland 6, Ohio

MEDICOLEGAL DIGEST

A monthly publication, Medicolegal Digest, which, for the first time, focuses upon major common concerns of two great professions—medicine and the law—was launched in May as a service to 161,000 physicians.

A dozen authorities in law, medicine, and hospital administration comprise the editorial board of the new journal, which is being distributed to family doctors and specialists in private practice. One of the board members is. Ray E. Brown of Chicago, superintendent of the University of Chicago Clinics and past president of the American Hospital Association. He was formerly an administrator of the North Carolina Baptist Hospital.

The editor of Medicolegal Digest is Milton Golin of Washington, D. C., formerly editor of the "Medicine At Work" section of the Journal of the American Medical Association.

FEDERAL AVIATION AGENCY

Effective June 15, 1960, the Federal Aviation Agency will require that student and private pilots be given their medical examinations by designated medical examiners. This rule reinstates a practice which was in effect from 1926 until 1945.

In announcing the reestablishment of this practice, Dr. James L. Goddard, the Civil Air Surgeon, has emphasized his previous statements that any physician may be considered eligible for designation as an examiner.

Those physicians in localities where flying activities are conducted may wish to consider filing an application for designation by writing to the Civil Air Surgeon, Federal Aviation Agency, Washington 25, D. C.

Designation as an aviation medical examiner will qualify the designee to examine both Class II (commercial) and Class III (student and private) airmen, including control tower operators. Instructions concerning the required procedures, standards, and equipment will be supplied to those who apply.

Since commercial and airline transport pilots have always been required to obtain examinations from specifically selected physicians, there are presently some 2,000 aviation medical examiners previously designated and located throughout the country. Expanding aviation activities will result

in a continuing need for additional examiners. There are at present some 400,000 active civil airmen of whom approximately 240,000 are examined each year.

OFFICE OF THE SURGEON GENERAL

Major General O. K. Niess, Surgeon General, U. S. Air Force, has announced the promotion of Colonel Raymond T Jenkins, USAF, MC, to Brigadier General, General Jenkins is the Director of Plans and Hospitalization, Office of the Surgeon General, Washington, D. C.

General Jenkins received his pre-med training at the University of North Carolina, Chapel Hill, North Carolina and graduate from the Duke University Medical School, Durham, North Carolina, with his M.D. degree in 1935.

U. S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Modern uses of medically approved treatments in saving a growing proportion of cancer patients are described in a new booklet, Treating Cancer, just issued by the Public Health Service of the Department of Health, Education, and Welfare.

In terms readily understandable to the layman, the publication explains how malignant diseases

plus the soothing, antipruritic, healing influence of pantothenylol



are treated by surgery or by radiation with k-rays, radium, or the newer radioisotopes from atomic sources. It also tells how drugs are used to treat cancer.

Single copies of Treating Cancer, Public Health Service Publication No. 690, may be obtained from the Public Health Service, Washington 25, D. C. The booklet may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 15 cents per copy.

New estimates, released by the Public Health Service today, show that over 91 million persons have now had one or more shots of polio vaccine and 72 million of them have had the three or more shots required for complete vaccination.

The estimates were developed by the National Foundation with data supplied by the Public Health Service and local chapters of the Founda-

The new figures indicate that 40 per cent of the population now has maximum protection against polio. Eleven per cent have been partially vaccinated with one or two injections, but 49 per cent have had no vaccine at all.

Public Health Service scientists have reported that a new family of compounds, decarboxylase

inhibitors, is providing a promising new approach to the understanding of hypertension and may eventually offer new means of treating this puzzling disorder.

Limited clinical trials of the most effective of these compounds, alpha-methyl dopa, have been conducted by scientists of the Service's National Heart Institute on 10 hypertensive patients at the National Institutes of Health Clinical Center. The drug lowered blood pressure in all of these

Alpha-methyl dopa was synthesized in 1950 by Drs. G. A. Stein, H. A. Bronner, and Karl Pfister of the Merck Sharp & Dohme Research Laboratories, Rahway, New Jersey. The clinical trials described are the culmination of extensive laboratory testing of this compound by Merck Sharp & Dohme scientists and by other scientists of this country, Canada, and Europe.

VETERANS ADMINISTRATION

Highly emotional stress or extreme, prolonged tension often raises the cholesterol level in the blood despite diet, proper exercise and rest, doctors at the Oklahoma City Veterans Administration hospital have found.

The doctors found that emotional tension alone can increase cholesterol 35 percent within an hour.



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VETERANS ADMINISTRATION

Appointment of Dr. Oscar Auerbach of the East Orange, New Jersey Veterans Administration hospital and Dr. Ludwik Gross of the Bronx, New York, VA hospital as senior medical investigators was announced by the VA in Washington, D. C., today.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Increased support for influenza research to permit investigators to take advantage of the study opportunities afforded by the current influenza outbreaks has been announced by Surgeon General Leroy E. Burney of the Public Health Service

Methods to stimulate research during the current influenza season and to encourage longrange research in influenza and related diseases were developed in January when Dr. Burney called together the Service's Committee of Investigators, which is composed of some of the Nation's leading authorities on influenza and related diseases.

THE WORLD MEDICAL ASSOCIATION

The Headquarters Secretariat of The World Medical Association announces the appointment of Dr. J. Gosset, editor of Concours Medical of Paris, France, to the position of Associate Editor of World Medical Journal, official publication of the Association.

Dr. Stanley S. B. Gilder, formerly editor of the Journal of the Canadian Medical Association is the executive editor of World Medical Journal. The members of the editorial board include the executive and associate editor the business Manager and three members of Council.

Sir William Osler's Essay "A Way of Life" Distributed Free

One of the great medical educators of modern times, Sir William Osler's observations and essays were a guide to his profession for two generations. In "A Way of Life," an address delivered to the students at Yale University in 1913, Osler outlined the philosophy of every-day living which guided him throughout medical school and in his successful career as physician, classical scholar, philosopher, and teacher.

This famous lecture, published in A Way of Life and Other Selected Writings of Sir William Osler (Dover, \$1.50), has now been reprinted as a separate booklet. Dover Publications is offering the booklet entirely free of charge to teachers of medicine, medical schools, hospitals and medical libraries.

"A Way of Life" is an expression of Osler's clear-sighted approach to the problems of living. It presents a solution that still has striking relevance to contemporary problems. Anyone who is interested in the lives and thoughts of the great medical personalities of our time will enjoy this inspiring essay. A copy of the booklet may be obtained without charge or obligation by writing directly to Dover Publications, Inc., 180 Varick Street, New York 14, New York.

The Month in Washington

Politics now overshadows all other factors in the issue of health care for the aged.

It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on the basic approach. The major Democratic plans call for use of the Social Security System. The Republican proposals would have the Federal government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

The medical profession and allied groups oppose these political solutions because, among many other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Meanwhile, a key Democrat—Representative Burr Harrison of Virginia—warned Congress against acting on such legislation

From the Washington Office of the American Medical Association, 1523 L Street, N. W.

Classified Advertisements

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in this year of a national election. He predicted that if any such legislation should be approved this year, it "would be certain to be a monstrosity."

Noting that various solutions had been proposed, Harrison said:

"The only features which these proposals have in common are that they are all tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly based and little understood by the prospective beneficiaries."

Harrison, who is a member of the House Ways and Means Committee which handles such legislation, urged that Congress defer action until next year. He recommended that, in the meantime, the Ways and Means Committee "conduct an exhaustive study of the various proposals."

In early May, the Eisenhower Administration unveiled a Federal-state, \$1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged person—if able financially—would bear part of the cost of both the insurance and of the medical care and hospitalization.

The Scientific Exhibit

AMA Clinical Meeting, Washington, D. C.

November 28-December 1, 1960

Application forms for space in the Scientific Exhibit at the Washington, D. C. Cilnical Meeting of the American Medical Association, November 28 to December 1 are now available. They may be procured by writing directly to Charles H. Bramlitt, M.D., Director, Department of Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois. Applications close on August I.

The "Hull" award will be presented for the first time at this meeting to the best exhibit on a scientific subject which has not been previously shown at a medical meeting. The award will consist of a gold medal and an honorarium of \$250. The winning exhibit will be approved for showing in the Scientific Exhibit at the 1961 Annual Meeting of the AMA which will be held in New York City.

Dr. Thomas G. Hull will personally present the award to the recipient.

BOOK REVIEWS

Significant Trends in Medical Research. Ciba Foundation Tenth Anniversary Symposium. Editors for the Ciba Foundation, G. E. W. Wolstenholme, Cecilia M. O'Connor, and Maeve O'Connor. 356 pages. Price, \$9.50. Boston: Little, Brown and Company, 1960.

A distinguished group of 30 research workers from several countries, met in London in June, 1959 in a symposium celebrating the tenth anniversary of the opening of the Ciba Foundation. This volume contains the contributions of those 14 who presented papers, together with the equally illuminating and interesting discussions which followed the papers.

In general, the papers are in the nature of reviews, ranging from a discussion of medical research in the United States by J. A. Shannon, director of the National Institutes of Health, to fluorimetric studies of pyridinenucleotide enzyme complexes by Prof. H. Theorell of the Nobel Institute, Stockholm; the latter is the most restricted of the topics considered. The eminence of the participants, and the general nature of the symposium, insures a broad and provocative outlook on the different subjects. The editing of the discussions has not been so restrictive that the personal imprint of the discussants cannot be detected, which lends considerable interest to their contributions. The predictions of future trends which the authors make in the course of their reviews are not often included in scientific papers per se, being somewhat nonscientific in essence.

The volume is recommended to anyone interested in brief reviews by eminent authorities of some of the most important fields of medical research in our time, accompanied by discussions from well-informed people who are not expert in the subject of the papers, who thus tend to bring our relations between the subject and other fields. Contained within the topics considered may well be the most important medical advances of the next decade.

Medical, Surgical and Gynecological Complications of Pregnancy. By the Staff of Mount Sinai Hospital. Edited by A. F. Guttmacher, M.D., and J. J. Rovinsky, M.D. 500 pages. Price, \$16.50. Baltimore: The Williams and Wilkins Company, 1960.

In an article entitled "Red Lights in Obstetrics," published in the Journal of the Iowa State Medical Society for January, 1951, the late Dr. Samuel A. Cosgrove stated that "....sick women will get pregnant, and pregnant women will get sick." Despite tacit recognition of the occurrence and interplay of coincidental medical and surgical complications during gestation, "medical obstetrics" is of relatively recent vintage and has re-

BOOK REVIEWS 259

ceived but passing mention in standard medical and surgical references and only brief consideration in domestic and foreign obstetric texts. Except for occasional monographs on special subjects, thorough coverage of the intermediate areas of medical practice represented by Dr. Cosgrove's remark has not been readily available to either the medical practitioner or the obstetrician. Accordingly, the volume edited by Drs. Guttmacher and Rovinsky, which embodies the integrated philosophy of medical and obstetric practice at the Mt. Sinai Hospital, is a valuable supplement to existing textbooks on obstetrics (and those of medicine as well).

Obviously in any medical literary collection or review, the emphasis, inclusion, or exclusion of specific subjects is determined by the author or editorial staff. A lack of overall balance in subject matter may result, a situation that appears to have been properly avoided in the present volume in which cardiovascular, pulmonary, renal and metabolic problems have been given deserved emphasis and coverage. Likewise, the sections on surgical and gynecologic complications are considered adequate. Appropriate attention is given to special areas such as otolaryngology, neurology, dermatology, ophthalmology, and gastroenterology, including diseases of the liver. A particularly valuable section devoted to genetics is timely and of interest in consideration of current popular concern with the biologic effects of radiation. The combined experience of the Mt. Sinai staff in dealing with clinical problems occurring in these and other areas together with citation of the current literature and bibliographic material appended to each chapter provide a valuable reference source for any physician attending obstetric patients.

The editors and authors are to be congratulated for their efforts in the production of this important contribution to this long neglected specialized area within the field of obstetries.

First Aid: Diagnosis and Management. By Warren H. Cole, M.D. and Charles B. Puestow, M.D., with 16 Collaborating Authors. 432 pages. Price, \$6.25. New York: Appleton-Century-Crofts, Inc., 1960.

This revised and expanded text is an authoritative guide to the emergency care of all types of injuries, shock or medical emergencies resulting from accidents, industrial hazards, civilian or military casualties including atomic blast, burn and radiation types.

Subjects such as wounds, burns, hemorrhage, shock, poisoning, bandaging, splinting, transportation of the injured and physical failure are cov-

ered in detail, with emphasis placed on what not to do as well as upon what to do.

While prepared specifically for the use of physicians and students of the biological sciences, particularly those in the MEND program, it is almost equally useful as a training guide for rescue squad personnel, civilian defense trainees, police and fire department, accident and catastrophe squads, and non-commissioned medical personnel of the armed services.

In Memoriam

Bryan Nazer Roberts 1898-1960

Dr. Roberts received his A.B. at the University of North Carolina in 1921. After completing the two-year medical course, he transferred to the University of Maryland where he received his M.D. degree in 1925. He interned one year at Watts Hospital, then entered general practice in Columbus County. He returned to the University of Maryland Hospital in 1929 for an additional year of internship, following which he entered general practice in Hillsboro, North Carolina. His domestic life was enlarged by his marriage in 1925 to Jean Lower, and their union was blessed by the birth and survival of two sons.

Dr. Roberts served well the community of Hillsboro and its environs as family physician, adviser, and friend. His unselfish devotion to duty is best attested to by the many friends who mourned his passing.

Dr. Roberts found joy and relaxation in the circus, and he attended all those within driving distance of Hillsboro. This avocation served him well in 1953 when ill health forced him to retire temporarily from the arduous duties of general practice. During his convalescence he served as physician with Ringling Brothers, Barnum and Bailey Circus for one year. Being restored to health and vigor, he returned to Hillsboro where he resumed practice and continued in it until his death.

WHEREAS, Dr. Roberts was an active member of the Durham-Orange County Medical Society and regularly attended its meetings; and

WHEREAS, his death removed one of the few remaining general practitioners in this society which, at its inception, was composed almost entirely of men in general practice; be it

Resolved that the Society express its grief at the loss of a loyal member and convey its sympathy to his wife and children in their loss of a devoted husband and father; be it further

Resolved that these statements be spread upon the minutes of this Society and a copy be sent to the family.

Durham-Orange County Medical Society Jack Hughes, M.D. Secretary-Treasurer

Major Ivey Fleming, M.D. (1880-1960)

Dr. Major Ivey Fleming died after a brief illness in Park View Hospital. Rocky Mount, North Carolina, on January 26, 1960, at the age of 79. His passing will be deeply felt by his patients, friends, and professional colleagues, all of whom benefited from his kindness, unfailing good humor, and professional accomplishments.

Dr. Fleming was born on September 1, 1880, in Greenville. He spent his boyhood on his father's farm. In 1898 he entered the University of North Carolina to begin his medical career. He completed his training at the Jefferson Medical College in Philadelphia, receiving his M.D. degree in 1905, followed by a year's internship.

He was in general practice in Hamilton, North Carolina, for a number of years. While there he met his wife, the former Jerusha Lucille Sherrod.

In 1918, he became one of the first staff members of the recently organized Park View Hospital. After a short time, his interest turned to the relatively new specialty of roentgenology; and he took postgraduate courses in Richmond. Philadelphia, and New York, in this subject. He then organized and headed the department of radiology at Park View Hospital, one of the first in eastern Carolina.

Dr. Fleming also took an interest in his specialty outside the local scene. He was one of the organizers and charter members of the North Carolina Radiological Society. He was president of this group for one year and secretary for 18 years.

On January 1, 1953, Dr. Fleming retired from active practice. He soon tired of inactivity, however, and opened an office for general practice in

Battleboro. He remained active here until his last illness, serving an area which had been without a physician for several years.

Beside the North Carolina Radiological Society, Dr. Fleming was an active member of the Edge-combe-Nash County Medical Society, North Carolina State Medical Society, staff of Park View hospital, and he was roentgenologist for Memorial Hospital, Rocky Mount, North Carolina. In 1958 he was honored by the presentation of a 50 year service pin by the North Carolina State Medical Society.

He belonged to many non-professional organizations. Among those in which Dr. Fleming was most interested and which reflected his love of the outdoors might be mentioned the Roanoke and Tar River Gun Club and the Benvenue Country Club. He was an organizer and charter member of both.

He is survived by his wife, Mrs. Jerusha Sherrod Fleming, of Rocky Mount; and by two sisters, Mrs. Nana Brown of Statesville, and Mrs. Nannie White of Greenville.

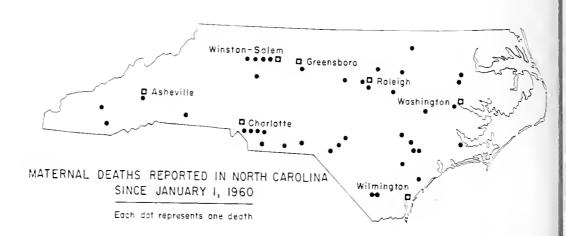
WHEREAS it has pleased Almighty God to take from our midst Major Ivey Fleming.

Be it resolved, That we do mourn the loss of our fellow member of the Edgecombe-Nash County Medical Society; and

That we extend our sympathy and understand to his widow, Jerusha Fleming; and

That a copy of these resolutions be spread upon the minutes of this Society, and a copy be sent to Mrs. Fleming, and to the North Carolina State Medical Society.

> E. L. Seigman, M.D. J. R. Chambliss, M.D. L. S. Thorp, M.D.

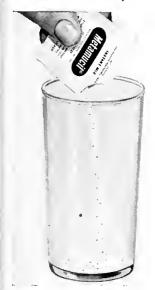


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Colitis? Gall Bladder Disease? Chronic Appendicitis?

Rheumatoid Arthritis? Regional Enteritis?

DISEASE that is frequently overlooked in solving diagnostic quandaries is amebiasis. Its symptoms are varied and contradictory, and diagnosis is extremely difficult. In one study, 56% of the cases would have been overlooked if the routine three stool specimens had been relied on.¹

Another study found 96% of a group of 150 patients with rheumatoid arthritis were infected by *E. histolytica*. In 15 of these subjects, nine stool specimens were required to establish the diagnosis.²

Webster discovered amebic infection in 147 cases with prior diagnoses of spastic colon, psychoneurosis, gall bladder disease, nervous indigestion, chronic appendicitis, and other diseases. Duration of symptoms varied from one week to over 30 years. In some cases, it took as many as six stool specimens to establish the diagnosis of amebiasis.³

Now treatment with Glarubin provides a means of differential diagnosis in suspected cases of amebiasis. Glarubin, a crystalline glycoside obtained from the fruit of *Simarouba glauca*, is a safe, effective amebicide. It contains no arsenic, bismuth, or iodine. Its virtual freedom from toxicity makes it practical to treat

suspected cases without undertaking difficult, and frequently undependable, stool analyses. Marked improvement following administration of Glarubin indicates pathologically significant amebic infection.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis.

Glarubin*

TABLETS

specific for intestinal amebiasis

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin.

Write for descriptive literature, bibliography, and dosage schedules.

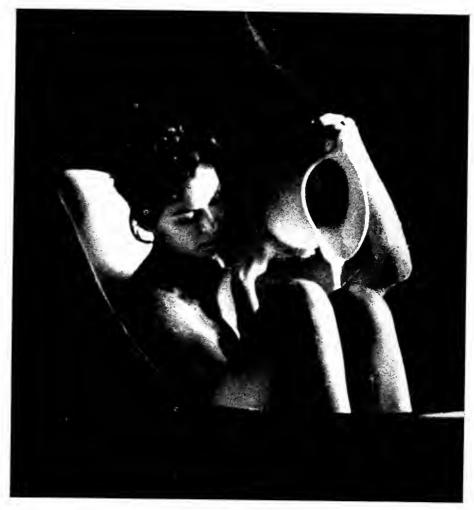
- Cook, J.E., Briggs, G.W., and Hindley, F.W.: Chronic Amebiasis and the Need for a Diagnostic Profile, Am. Pract. and Dig of Treat. 6:1821 (Dec., 1955).
- 2. Rinehart, R.E., and Marcus, H.: Incidence of Amebiasis in Healthy Individuals, Clinic Patients and Those with Rheumatoid Arthritis, Northwest Med., 54:708 (July, 1955).
- Webster, B.H.; Amehiasis, a Disease of Multiple Manifestations, Am. Pract. and Dig. of Treat. 9:897 (June, 1958).

*U.S. Pat. No. 2,864,745

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Many women don't know that a vinegar douche is as old-fashioned as the copper tub, a relic of an empiric age. Acids actually make mucus discharge more tenacious. On the other hand, soaps and harsh alkali are irritating. A detergent douche — TRICHOTINE, the only major douche containing sodium lauryl sulfate — is the modern, more

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The detergent action of TRICHOTINE assures greater penetration of viscid mucus, better dispersion of the healing medicaments on the mucosal surface, and more efficient removal of vaginal discharge.

If there is any doubt in your mind, compare TRICHOTINE with vinegar or any other

Goodman, L.S. and Gilman, A.: The Pharmacologic Basis of Therapeutics, MacMillan, 1955.



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The pH changes produced by any low pH douche last only a few minutes² and are of questionable value in healing.³ TRICHOTINE actually favors epithelial growth and

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TRICHOTINE is indicated in the management and treatment of cervicovaginitis and leukorrheas, alone or in conjunction with other antimicrobials. TRICHOTINE is ideal for routine feminine hygiene — safe, gentle and effective.

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Karnaky, K.J.: J.A.M.A. 157:1155, 1955 (August)
 Scheinberg et al: Surgery 24:972, 1948 (Dec.).

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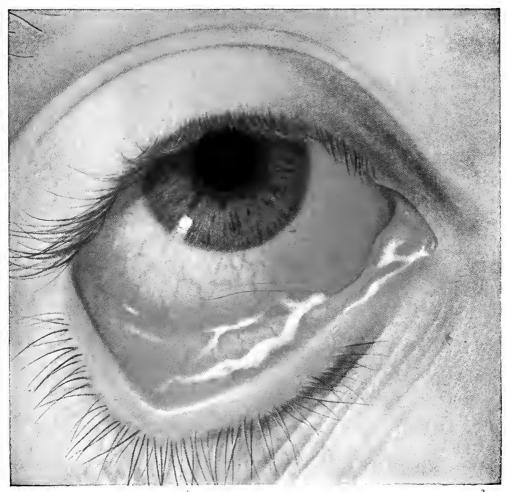
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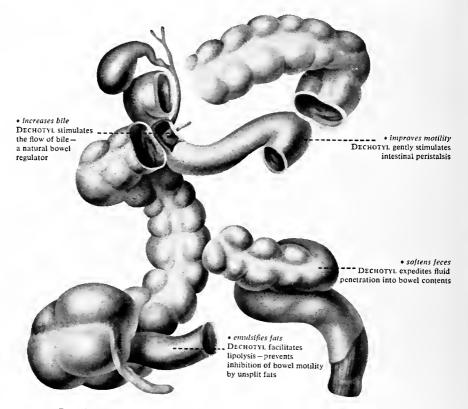
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1 Lippmann, O : Arch Ophth. 57:339. March 1957 2. Gordon, D.M.. Am J. Ophth. 46:740, November 1958. supplied: O.5% Sterile Ophthalmic Solution NEO. HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL*. In 5 cc. and 2.5 cc dropper vals. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

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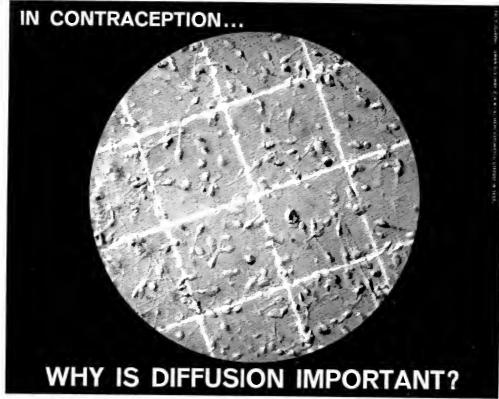
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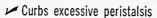


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- ✓ Soothes inflamed mucosa
- Provides intestinal antisepsis

FORMULA: Each 15 cc. (tablespoon) contains:

Sulfaguanidine 2 Gm. Pectin 225 mg.

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Opium tincture0.08 cc. (equivalent to 2 cc. paregoric)

DOSAGE: Adults: Initially 1 or 2 tablespoons from

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- *SANTA ROSA, CALIFORNIA Friday, September 16, 1960 The Flamingo Hotel
- *KANSAS CITY, KANSAS Friday, September 23, 1960 Battenfeld Memorial Auditorium

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- *GREAT FALLS, MONTANA Saturday, October 22, 1960 The Rainbow Hotel

ROCHESTER, NEW YORK Wednesday, October 26, 1960 The Manger Hotel CHARLESTON, WEST VIRGINIA Sunday, October 30, 1960 The Daniel Boone Hotel

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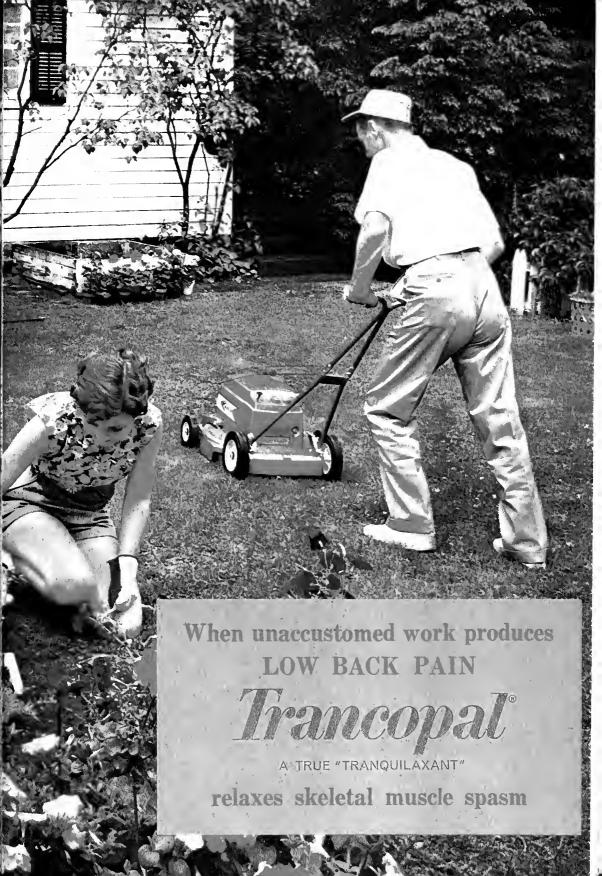
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ichtman^{1,2} used Trancopal to treat paients with low back pain, stiff neck, ursitis, rheumatoid arthritis, osteorthritis, trauma and postoperative uscle spasm. He noted that Trancopal rought satisfactory relief to 817 of 879 atients (excellent in 268, good in 448, air in 101). "Chlormethazanone [Tranopal] not only relieved painful muscle pasm, but allowed the patients to reume their normal activities with no inerference in performance of either nanual or intellectual tasks."

Fruenberg³ also prescribed Trancopal or 70 patients with low back pain and beerved that it brought marked improvement to all of them. "In addition a relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restless-

ness and irritability in a number of patients." In another series of 193 patients Kearney obtained relief with Trancopal in 181 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."3 Lichtman¹ found that his patients in anxiety and tension states "... were in many instances able to continue their normal activities where previously they had been considerably restricted in their activities." ... Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available." (Kearney)4

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use." In the 70 patients with low back pain treated by Gruenberg, the only side effect noted was a mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."

Trancopal

potent muscle relaxant effective tranquilizer

- In musculoskeletal disorders, effective in 91 per cent of patients.
- In anxiety and tension states, effective in 89 per cent of patients.⁵
- Low incidence of side effects (2.3 per cent of patients).

 Blood pressure, pulse rate, respiration and digestive processes are unaffected by the apeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

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Low back pain (lumbago)
Neck pain (torticollis)
Bursitis
Fibrositis
Myositis
Ankle sprain, tennis elbow
Osteoarthritis
Rheumatoid arthritis
Disc syndrome
Postoperative muscle spasm

Psychogenic disorders
Dysmenorrhea
Premenstrual tension
Anxiety and tension states
Asthma
Angina pectoris
Alcoholism

How Supplied: Trancopal Caplets⁵



200 mg. (green colored, scored), bottles of 100.

100 mg. (peach colored, scored), bottles of 100.

Dosage: Adults, 200 or 100 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

References: 1. Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958 • 2. Lichtman, A. L.: Scientific Exhibit, Internat. Coll. Surgeons, Jan. 4-7, 1959, Miami Beach, Fla. • 3. Gruenberg, F.: Current Therap. Res. 2:17, Jan., 1960 • 4. Kearney, R. D.: Current Therap. Res. 2:127, April, 1960 • 5. Collective Study, Department of Medical Research, Winthrop Laboratories.

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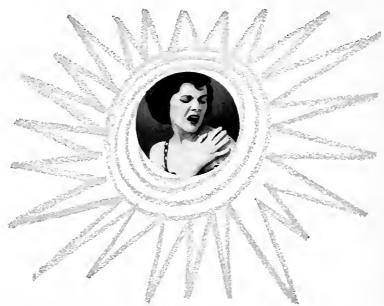
Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

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*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec.19) 1959. Scottle Francet 2:1105



for **dryness** and **itching**, prickly heat and rash intertrigo, insect bites, other summer skin discomforts



1. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958

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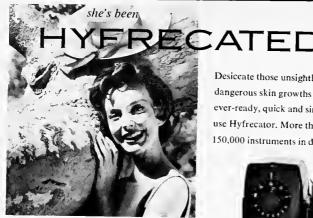


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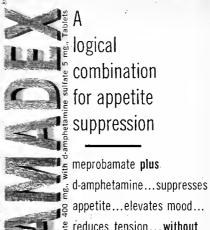


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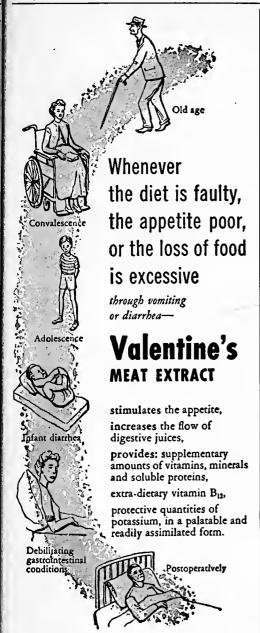
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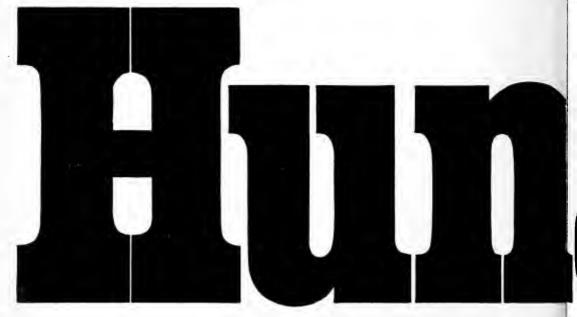
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ntestinal Amebiasis cute, subacute, aronic)	Adults: 0.75 to 1.5 Gm.; larger doses when required.	5 days
	Children: 22 mg/Kg; larger doses when required.	5 days
reoperative uppression of itestinal Flora	Adults: 2 Gm.	4 days
epatic Coma	Adults: up to 6 Gm., depending on degree of hepatic insufficiency and response of potient.	See literature

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